FLORIDA DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL REPORT 2005

DOMESTIC VIOLENCE FATALITY REVIEW TEAM
2005 ANNUAL REPORT EXECUTIVE SUMMARY

Domestic Violence Fatality Review Teams were first formed in Florida in the mid – 1990's. These teams began as local initiatives supported with federal grant funds. Their goal is to examine in-depth, cases that result in a domestic violence fatality and identify changes in policy or procedure that might prevent future deaths. These teams work independently and are composed of representatives from municipal, county, state and federal agencies as well as individuals or organizations that are remotely involved with or affected by a domestic violence fatality. The composition varies from team to team.

The year 2004 brought four major hurricanes to Florida which caused devastation across the state. Many of the fatality review teams were affected by the damage and were unable to meet for several months. This impacted the number of domestic violence fatalities reviewed by the teams for submission to the FDLE for inclusion in the 2005 annual report. The decrease in the number of fatalities reviewed resulted in a significant reduction in the total number of domestic violence fatalities reported in this year's annual publication.

The cases reviewed for this annual report were independently selected by the fatality review team members and occurred during different years. Due to the teams' differing methods of selecting incidents for review and the changing number of fatality review teams, the data are not provided as a year-to-year comparison. For the reasons noted above, caution should be taken before attempting to generalize or draw conclusions about state policy based on this limited and unscientific sample.

The data in this report are based on the reviews of 24 cases involving 29 decedents and 24 perpetrators and is not meant to statistically represent all domestic violence deaths in Florida. Four of the 24 cases reported involved multiple victims (three in one case and two in three cases). Fourteen (58%) of the 24 cases occurred in/at the residence of the decedent and perpetrator. In 18 (75%) of the 24 cases, the parties lived together at time of death. In 13 (54%) of the 24 cases, prior incidents of domestic violence had been reported. In 17 (71%) of the 24 cases, the parties had experienced a significant change in the relationship. Profiles of the perpetrator and decedent are listed below.

Perpetrator

- 22 (92%) were male
- 2 (8%) were female
- 12 (50%) were White
- 11 (46%) were Black
- 1 (4%) was Asian/Pacific Islander
- 42 was the average age

Decedent

- 24 (83%) were female
- 4 (14%) were male
- 1 (3%) unknown sex (unborn child)
- 17 (59%) were White
- 11 (38%) were Black
- 1 (3%) Other (Dominican Republic)
- 43 was the average age

In 2005 the Florida Legislature approved and Governor Bush signed House Bill 1921, Review Under the Open Government Sunset Review Act. The bill expands the exemption from public records requirements for confidential or exempt information obtained by a domestic violence fatality review team to include information that identifies a victim or the children of the victim of domestic violence. All information a Domestic Violence Fatality Review Team acquires from individuals or entities shall now remain confidential.

The data were gathered from the Annual Summary Evaluation Forms that were provided to the FDLE's Domestic Violence Data Resource Center (DVDRC) by the participating Domestic Violence Fatality Review Teams. Other findings, changes and recommendations can be found in Appendix A, where the Fatality Review Teams' individual case reviews are provided. Many of these issues are currently addressed by Florida law.

The following changes were implemented locally by the Domestic Violence Fatality Review Teams based on the cases reviewed for the 2005 reporting period.

- The Bay County Sheriff's Office established a Domestic Violence Unit to provide better services for victims and to pursue cooperative efforts with other local law enforcement agencies, as well as other service providers.
- The Broward Chiefs of Police Association adopted Uniform Protocols for Police Based Victim Advocates. All Broward County police agencies will follow these protocols when responding to cases of domestic violence.
- All participating agencies of the Palm Beach County Fatality Review Team do internal and external agency training to various organizations.
- The Palm Beach County Fatality Review Team responds to local newspapers in response to insensitive articles written regarding domestic violence cases.
- Surviving family members are linked with needed services as a result of the Palm Beach County Fatality Review Team's work.
- Two brochures were created in Pinellas County that address friends/family of domestic violence victims or perpetrators and seniors that are impacted by domestic violence.
- Polk County's Sheriff's Office and Court created an order with specific instructions for respondents who are required to surrender firearms in injunction for protection cases.
- Brevard County now has open dialogue with courts to resolve issues regarding restraining orders.

The following findings were identified by the Domestic Violence Fatality Review Teams based on the cases reviewed for the 2005 reporting period. Findings are compiled from all reporting teams.

- Although there are a variety of services available to victims of domestic violence, they aren't being used and there is nothing law enforcement or service providers can do to change this except to continue to make the victims aware of the existing services and encourage them to use them.
- In some areas there is no substance or mental health treatment available, no family awareness of services.
- There is a gap of services for at-risk children, i.e., DCF, School.

- Victim safety would benefit from the availability of a counseling service explaining the implications of their decision for individuals contemplating divorce, safety issues exacerbated by divorce/separation and the propensity for domestic violence with this decision.
- Mental health issues play a large part in the fatalities.
- There is a need for more education and awareness to the public on domestic violence issues.
- Cases reviewed had many common factors, i.e. use of firearms, abuse of drug and alcohol by both perpetrator and decedent. In all cases other entities were aware of escalating abuse.
- All the perpetrators, who were men, exhibited over 10 of the lethality indicators with the highest numbers in the "ownership/centrality" of decedent to perpetrator.
- The most significant finding was the system's ineffectiveness when dealing with complex relationship issues.
- Many times the victim appeared to not recognize the high risk of lethality until only a short time prior to the death.
- There is a need for training between domestic violence and substance abuse disciplines.
- A large number of cases involve suicide.
- Substance use/abuse continues to be a problem in many cases.
- Friends/family/coworkers often know about violence but do not know how to intervene.

The following recommendations were made by the Domestic Violence Fatality Review Teams based on the cases reviewed for the 2005 reporting period.

- Arrest for domestic violence with a previous battery conviction of any kind should bump the newest charge to a felony, as opposed to the decision being made by officer discretion.
- Publish any civil procedures in newspapers regarding domestic violence and/or dating violence.
- Provide law makers with actual domestic violence fatality reports to impress upon them the need for more funding for domestic violence services.
- Establish a centralized data base for law enforcement, domestic violence providers and the judicial system to access which contains civil and criminal case information.
- More funding for mental health issues' programs.
- More funding for domestic violence programs.
- More community education on domestic violence.
- More mandatory training for law enforcement, judges and legal professionals.
- There needs to be a consistency in the sentencing of convicted domestic violence perpetrators. Taking into account any pre-trial diversion programs for domestic violence.
- A standard for probation that will ensure timely referrals to court-ordered resources.
- Competent follow-up by probation officers and timely violations of probation when court-ordered sanctions are not completed.
- Mandated interdisciplinary training for professionals working with the substance abuse and domestic violence communities to ensure personnel interface between the two treating entities.

- Increase funding to mandate local law enforcement to employ victim advocates in every law enforcement agency. A domestic violence fatality is often preceded by a recent verbal domestic dispute. Agencies that have victim advocates utilize them in tracking and analyzing these incidents. This enables the agency to be proactive in preventing and/or predicting when a domestic violence fatality is most likely to occur.
- Continual lethality training within the legal system, probation and social service providers.
- Increased education and awareness in regards to the high percentage of domestic related fatalities that involve a firearm.
- A follow-up in court on all domestic violence injunction cases, 3-6 months after the initial hearing to see if terms are being carried out.

The following comments and concerns were expressed by the Domestic Violence Fatality Review Teams based on the cases reviewed for the 2005 reporting period.

- Many cases involve vicious murder of the family pet and there is a need to track animal or pet involvement in domestic violence cases more extensively.
- Fatality Review Teams are concerned about funding, i.e. grants being reduced or taken away for domestic violence services.
- Teams feel their work in reviewing these cases is valuable and feel it should continue.
- Supportive outreach network in the community helps to encourage community members to reach out for assistance when they suspect cases of domestic violence within their own communities.
- Congratulations on the confidentiality law for fatality review teams that just passed in the recent legislative session.

All data and recommendations are the products of the participating Domestic Violence Fatality Review Teams, compiled and reported by the FDLE in compliance with Section 741.316, Florida Statute.

The FDLE wishes to thank the Domestic Violence Fatality Review Teams upon whose work this report relies. Their assistance and cooperation have been extremely valuable.
This report will be posted on the FDLE web site at www.fdle.state.fl.us.

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DOMESTIC VIOLENCE FATALITY REVIEW TEAM
2005 ANNUAL REPORT

The 2005 annual report contains information collected from the past three years. FDLE's goal is to accurately report the information provided by the local teams. Due to the differing methods of selecting incidents for review, and the changing number of participating Fatality Review Teams (FRT), the data are not provided as a year-to-year comparison. However, caution should be taken before attempting to generalize or draw conclusions regarding consistencies of patterns when reviewing the data for the three years.

DOMESTIC VIOLENCE IN FLORIDA

According to the Uniform Crime Reports Annual Report, Crime in Florida, a total of 119,772 domestic violence incidents were reported in 2004. Domestic violence accounted for 34% of all comparably reported violent offenses and simple assault.

Domestic violence accounted for 184 (19%) of the State's 946 murders during the same reporting period. The spouse or live-in partner was the victim in 56% of these offenses. Children accounted for 18% of the victims.

Although the statistics for the Crime in Florida report are based on statewide participation of all law enforcement agencies and the Domestic Violence Fatality Review Team Annual report is based on a smaller selection of cases, a comparison of the Crime in Florida and Fatality Review Team data revealed similar values when computing the percentage of fatalities by the victim to offender relationship.

Victim Relationship	Crime in Florida	Fatality Review Team
Spouse	35%	34%
Parent	9%	10%
Child	18%	7%
Other Family	5%	3%
Co-habitant	21%	38%
Other	8%	7%

As of May 10, 2005, there were 127,678 protection orders in the FDLE's Florida Crime Information Center's (FCIC) database.

DATA SUBMISSION FORM

Since the enactment of Section 741.316, Florida Statutes, effective July 1, 2000, the Domestic Violence Fatality Review Teams have used the standardized collection form provided by the FDLE to collect and record their findings of reported domestic violence related cases. In 2003 the standardized reporting form was revised and additional forms were created to capture multiple victim and perpetrator information. A by-stander form was created to capture secondary fatality victims who are not directly involved with the domestic violence incident. The teams began using the revised form and the newly developed multiple forms to record domestic violence fatality data for the 2005 annual fatality report.

ANNUAL SUMMARY FORM

A Domestic Violence Fatality Review Team Annual Summary Form was provided to each team to ensure that the appropriate findings and recommendations, derived from the reviews that the teams conducted, were provided to the Governor, President of the Senate, Speaker of the House of Representatives and Chief Justice of the Supreme Court. This form provides a mechanism for teams to highlight findings and/or issues that might not come to the forefront when data from all reviews are summarized.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM MEMBERS

Domestic Violence Fatality Review Teams currently consist of members representing the local law enforcement agencies, State Attorney's Office, Clerk of the Court, Court Administrator's Office, Medical Examiner's Office, Domestic Violence Centers, victim services, batterer's intervention program providers, Department of Children and Families (DCF), shelters, other state agencies, business entities, county probation and corrections, local animal shelter, local clergy, child death review teams and/or other involved parties. The composition varies from team to team.

FLORIDA'S DOMESTIC VIOLENCE FATALITY REVIEW TEAMS

As of the beginning of the year 2004, the following counties had active Domestic Violence Fatality Review Teams: Bay County, Brevard County, Broward County, Columbia County (also reporting for Madison, Taylor, Lafayette, Dixie, Hamilton and Suwannee counties), Miami-Dade County, Duval County, Escambia County, Lee County, Orange County, Palm Beach County, Pinellas County, Polk County and Sarasota County (also reporting for Manatee and Desoto counties). Seminole County has just formed a team and will be participating next year.

The following 10 teams submitted Domestic Violence Fatality Review Team Data Submission Forms in compliance with Florida Statute s. 741.316 for inclusion in the 2005 annual report. Additionally, these teams provided individual case review information and an overview of the critical findings resulting from the reviews conducted for this reporting period. The team and the number of reviews conducted and submitted are reflected below.

TEAM	REVIEWS
BAY	2
BREVARD	1
BROWARD	2
ESCAMBIA	1
LEE	3
ORANGE	1
PALM BEACH	2
PINELLAS	4
POLK	6
SARASOTA	2

The Escambia County Domestic Violence Review Team was only able to submit one report this year due to the devastating damages of Hurricane Ivan. Most buildings suffered damage including the Judicial Building where the Fatality Review Team meetings are held. Due to the damage and the problems incurred by most people at their place of business and their homes, the Escambia County Review Team did not schedule a Fatality Review Team meeting from the time Ivan hit, September, 2004, through February, 2005.

The Seminole County Domestic Violence Fatality Review Team continues to organize and develop a group to effectively review their domestic violence fatalities. During this deliberative process, the team has identified deaths caused by or traceable to domestic violence and maintains a commitment to investigate. Last year, the team encountered a number of road blocks, including Hurricanes Charley, Frances and Jeanne. The team plans to develop recommendations for coordinated community prevention and intervention initiatives.

The Orange County Domestic Violence Fatality Review Team spent a majority of its time examining the way they were conducting their fatality reviews during the calendar year of 2004. As a result of the examination the team revamped the entire process and has found it to be more efficient during reviews.

The Columbia County Fatality Review Team met over the course of calendar year 2004, however there were no findings that any of the cases reviewed were actually verified as domestic violence fatalities. There was one case which is still unsolved where a young woman, who was a domestic violence victim, was found in the middle of the road. This case is still actively under investigation and the team anticipates reporting on this case in 2006. The overwhelming number of cases looked at were suicides or accidental deaths which had a component of alcohol or substance abuse. The team will continue to review cases and report as each is verified.

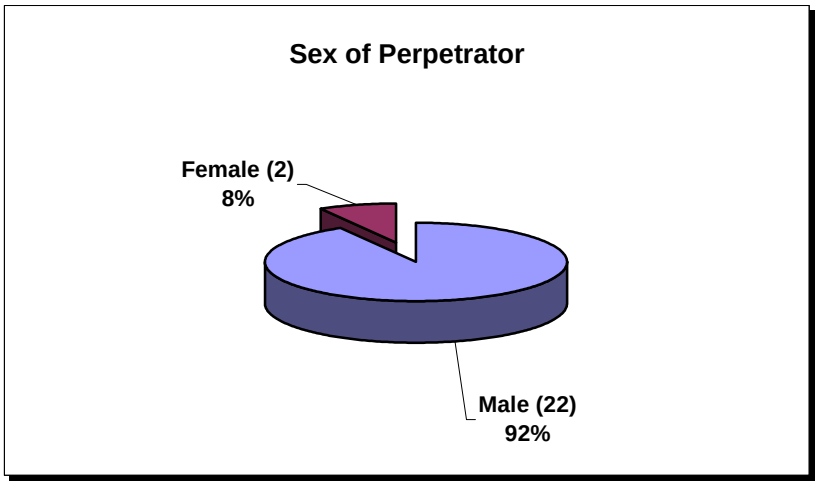
The Putnam/Volusia County Domestic Violence Fatality Review Team and the Collier County Domestic Violence Review Team are currently inactive. The Duval County Domestic Violence Fatality Review Team provided only the summary information for their team due to the volunteer's heavy workload and their commitment to their county's annual report. The Miami-Dade County Domestic Violence Fatality Review Team provided only summary information for inclusion in the statewide report.

Highlights of the 2005
Domestic Violence Fatality Report

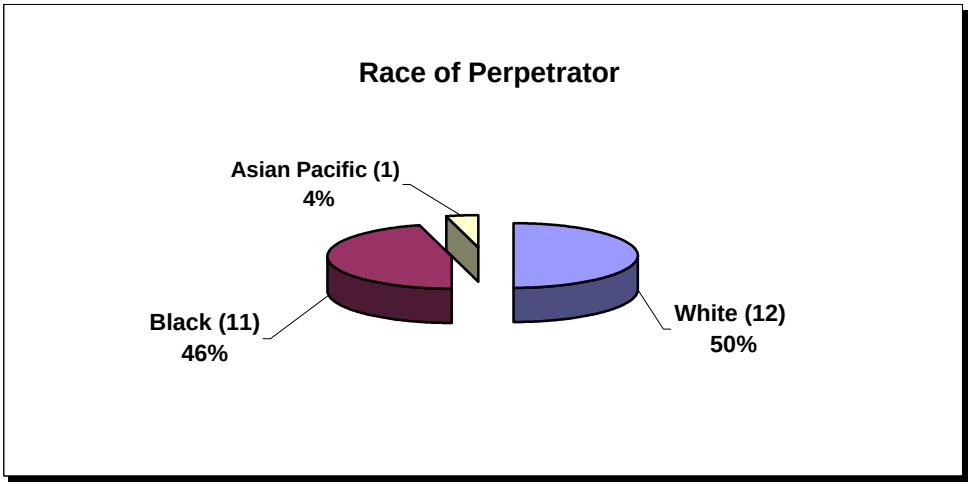
DOMESTIC VIOLENCE DATA REVIEW

The following data are from **24** cases provided to the FDLE's DVDRC by the participating Domestic Violence Fatality Review Teams. **The cases were not selected based on any specific date, time frame or circumstance. The data are from 10 teams covering only 12 counties, and the number of reviews completed by each team varies. Therefore, the reader is cautioned about drawing conclusions from this data.**

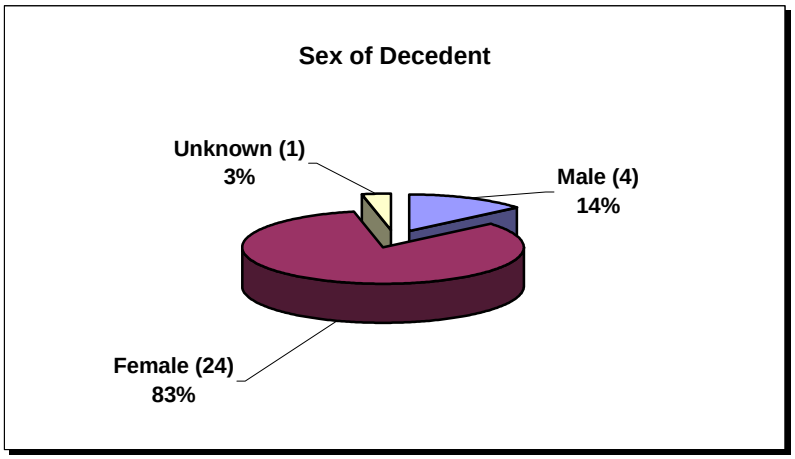
Perpetrator Profile



Perpetrator Age	
1-10 years of age	0
11-20 years of age	0
21-30 years of age	4
31-40 years of age	7
41-50 years of age	7
51-60 years of age	5
61-70 years of age	1
71-80 years of age	0
81-90 years of age	0
Average Age	**42**

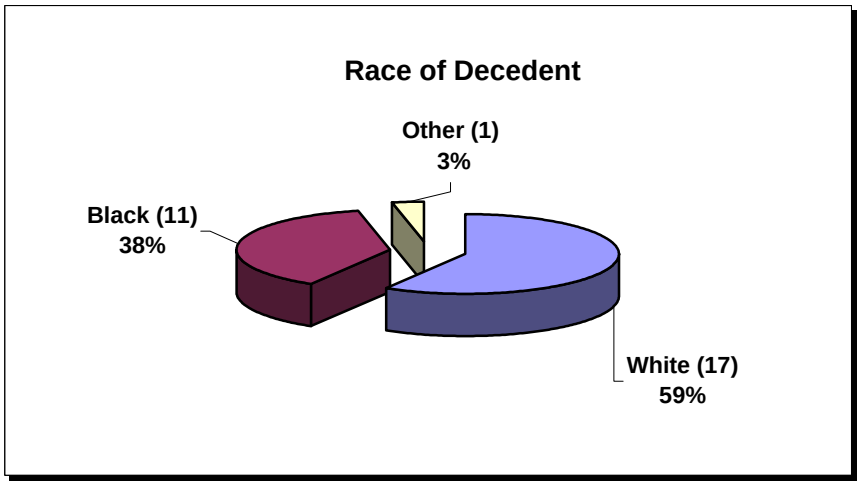


Decedent Profile

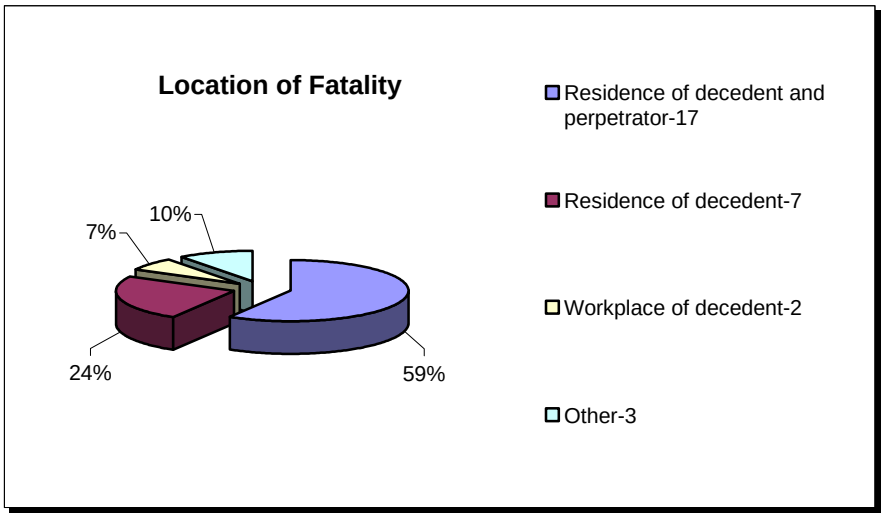


Decedent Age	
*1-10 years of age	2
11-20 years of age	1
21-30 years of age	4
31-40 years of age	8
41-50 years of age	4
51-60 years of age	6
61-70 years of age	2
71-80 years of age	0
81-90 years of age	2
Average Age	**43**

** Includes one unborn child*



Location of Fatality

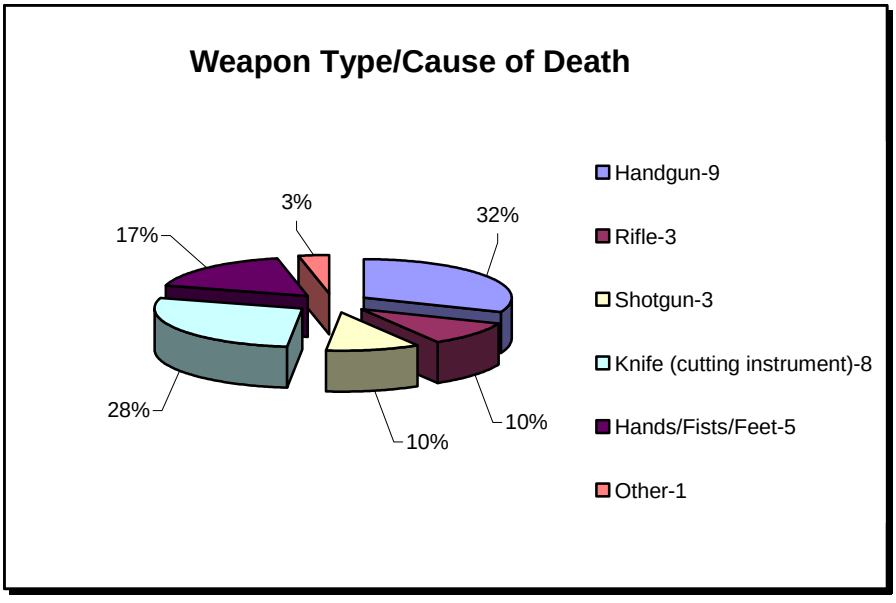


This chart depicts the location of the fatality of each of the **29** victims.

Four of the 24 cases reported involved multiple victims (three in one case and two in three cases) totaling **29** fatalities.

Fourteen (58%) of the 24 cases, involving 17 (59%) of the 29 victims, occurred in/at the residence of the decedent and the perpetrator.

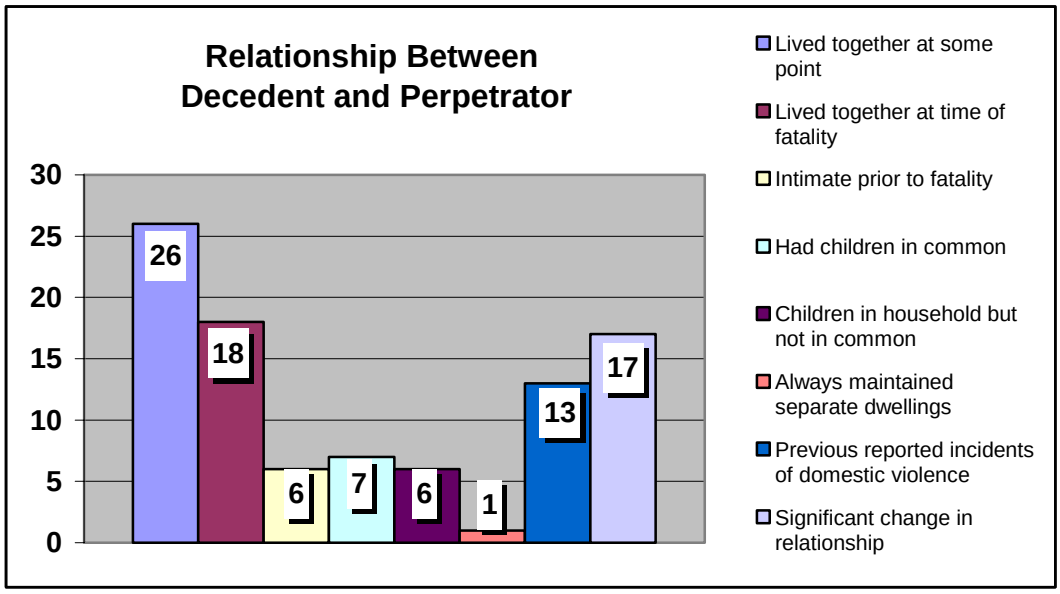
Weapon Types



This chart depicts the type of weapon used to carry out the fatality of the **29** victims. Firearms accounted for **52%** of the **29** weapon types.

"Other" consists of the death of a unborn child. The fetus' death was a direct result of the fatal gunshot wound to the decedent.

Relationship Between Decedent and Perpetrator



Note: The Relationship Between Decedent and Perpetrator category contains multiple selection fields and the review forms may contain more than one response for this category.

Highlights of the Domestic Violence Fatality Reports for Years 2003-2005

Highlights of the domestic violence fatality reports reviewed for the years 2003 -2005

The tabulations contained in this table are based on the number of cases submitted for each reporting period.

Due to the use of differing sampling methods the data reflected in the following table are not provided as a year-to-year comparison. However, caution should be taken before attempting to generalize or draw conclusions regarding consistencies of patterns when reviewing the data for the three years.

	2003	2004	2005
Average Age of Perpetrator	42	38	42
Average Age of Decedent	41	37	43
Sex of Perpetrators	51 (85%) male 9 (15%) female	46 (87%) male 7 (13%) female	22 (92%) male 2 (8%) female
Sex of Decedents	11 (16%) male 56 (84%) female *(there were multiple victims in five cases: three in two cases and two in three cases)*	18 (30%) male 42 (70%) female *(there were multiple victims in four cases: five in one case and two in three cases)*	4 (14%) male 24 (83%) female 1 (3%) *unknown *unborn child *(there were multiple victims in four cases: three in one case and two in three cases.)*
Location	34 (57%) of the 60 cases occurred in/at the residence of the decedent and perpetrator	27 (51%) of the 53 cases occurred in/at the residence of the decedent and perpetrator	14 (58%) of the 24 cases occurred in/at the residence of the decedent and perpetrator.
Weapons	In 38 (63%) of the 60 cases a firearm was involved in the fatality	In 32 (60%) of the 53 cases a firearm was involved in the fatality	In 9 (38%) of the 24 cases a handgun was involved in the fatality. In 8 (33%) a knife was involved.
Relationship	In 31 (52%) of the 60 cases, the parties lived together at time of fatality	In 28 (53%) of the 53 cases, the parties lived together at the time of fatality	In 18 (75%) of the 24 cases, the parties lived together at the time of the fatality.
History	In 24 (40%) of the 60 cases, prior incidents of domestic violence had been reported	In 23 (43%) of the 53 cases, prior incidents of domestic violence had been reported	In 13 (54%) of the 24 cases, prior incidents of domestic violence had been reported.

Fatality Review Incident Information for Years 2003-2005

THE FOLLOWING SECTIONS CONTAIN SUMMARIES OF DATA SUBMITTED BY THE TEAMS ON THE STATEWIDE FATALITY REVIEW DATA SUBMISSION FORM.

Due to the use of differing sampling methods the summary data in the following sections are not provided as a year to year comparison. However, caution should be taken before attempting to generalize or draw conclusions regarding consistencies of patterns when reviewing the data for the three years.

COMPLAINANT INFORMATION - This information relates to the notification of law enforcement when the fatality occurred and is taken from the dispatch data collected.

Regarding the **24** domestic violence fatality reports reviewed for the **2005** reporting period, **7 (29%)** of the incidents occurred on the weekend (four on Saturday and three on Sunday). The majority **(67%)** of the calls were received during the time frames of **06:01 AM - 12:00 PM** and **12:01 PM – 06:00 PM. Thirty-one percent** of the calls were received from the perpetrator of the fatality and **19%** of the calls were received from a family member of the decedent. **Fifteen percent** of the calls were received from a neighbor. A maintenance man, a witness at a hotel, a deputy sheriff and the new intimate partner were reflected in the "other" category as the complainant of the fatality. **Nearly 70%** of the calls were received after the event.

TIME FRAME	2003	2004	2005
12:01 AM to 06:00 AM	9	15	**2**
06:01 AM to 12:00 PM	12	7	**9**
12:01 PM to 06:00 PM	19	15	**7**
06:01 PM to 12:00 AM	16	13	**5**
Unknown	4	3	**1**
Total	**60**	**53**	**24**

CALL RECEIVED	2003	2004	2005
After Fatality	45	36	**18**
During Fatality	13	17	**6**
No information provided	2	0	**0**

CALL RECEIVED FROM*	2003	2004	2005
Decedent	2	1	**2**
Perpetrator	8	8	**8**
Family member of decedent	14	12	**5**
Family member of perpetrator	8	9	**0**
Neighbor	16	10	**4**
Co-worker	6	1	**3**
Acquaintance of decedent	4	9	**0**
Acquaintance of perpetrator	2	2	**0**
Medical professional	2	1	**0**
Unknown	3	3	**0**
Other	8	9	**4**
Total	**73**	**65**	**26**

***Note: The Call Received From category contains multiple selection fields and the review forms may contain more than one response for this category.**

Twenty-six telephone calls were received regarding the 24 domestic violence fatality reports reviewed for the 2005 reporting period. This was due to multiple complainants recorded in two of the reports. The category of "Other" consists of: one maintenance worker, one deputy sheriff, one witness at a hotel and one new intimate partner.

EVENT INFORMATION - This information is a general overview of the fatality itself from the type of offense, activities, parties involved, weapon, injury types sustained during fatality (both to the decedent and the perpetrator) and the current status of the perpetrator of the offense. This information is available from the law enforcement initial offense or case report.

Of the **24** domestic violence fatality reports reviewed for the **2005** reporting period, there were four cases with multiple victims, resulting in a total of **29** fatalities. Firearms **(15)** accounted for **52%** of the **29** deaths. Over half of the decedents, **83%**, were killed in their own residences.

OFFENSE TYPE	2003	2004	2005
Homicide	30	31	**17**
Homicide / Suicide	24	18	**3**
Multiple Homicides	5	0	**1**
Multiple Homicides / Suicide	1	3	**3**
Hostage Homicide / Suicide	0	0	**0**
Hostage Multiple Homicides	0	1	**0**
Total	**60**	**53**	**24**

There were a total of 29 victims in the 24 incidents reviewed for the 2005 reporting period. The offense type category reflected that the perpetrator killed multiple victims in four of the fatality review reports. The review forms reflected three victims in one report and two victims in three reports.

EVENT TYPE *(OF FATALITIES**	2003	2004	2005
Intimate partner	49	41	**14**
Ex-intimate partner	**	1	**6**
Familicide			**2**
Parricide	9	2	**1**
Fratricide and/or Sororicide	1	0	**0**
Killing the competition	1	3	**0**
Killing of children by parents	6	5	**2**
Perpetrator kills batterer	1	3	**0**
Other	0	5	**1**
Total	**67**	**60**	**26**

***The Event Type (of Fatalities) category contained multiple selections in two of the cases reviewed for the 2005 reporting year. One of the fatality review cases in which a multiple selection was recorded reflected both parricide and other; the other case in which a multiple selection was recorded reflected the event types of ex-intimate partner and killing of children by parents.**

****Ex- intimate Partner was captured in the Intimate Partner category in the 2003 reporting period.**

"Killing of children by parents" includes one unborn child in the 2005 reporting period.

"Other" comprises the perpetrator killing the following: roommate (possible girlfriend of the decedent) in the 2005 reporting period.

WEAPON TYPES	2003	2004	2005
Handgun	35	34	**9**
Rifle	5	1	**3**
Shotgun	2	4	**3**
Firearm *(other/unknown)*	2	0	**0**
Knife /Cutting Instrument	19	11	**8**
Fire/Incendiary	0	1	**0**
Blunt Object	5	2	**0**
Hands/Fists/Feet	8	9	**5**
Drugs	1	0	**0**
Other	4	6	**1**
Total	**81**	**68**	**29**

This category depicts the 29 weapon types used to carry out the fatality of the 29 victims reflected in the 24 reports reviewed for the 2005 reporting period.

"Other" comprises the following: Unborn child died as a result of fatal gunshot wound to decedent in the 2005 reporting period.

LOCATION OF FATALITY	2003	2004	2005
Residence of decedent and perpetrator	34	27	**17**
Residence of decedent	12	7	**7**
Residence of perpetrator	4	10	**0**
Residence of other family members	1	0	**0**
Workplace of decedent	3	2	**2**
Commercial	0	3	**0**
Other	6	11	**3**

Regarding the 29 domestic violence fatalities reviewed for the 2005 reporting period, "Other" comprises the following locations: one hotel, one wooded area, one street.

ENVIRONMENT PRIOR TO FATALITY - This information is related to the history of the perpetrator and the decedent as it related to children and domestic violence injunctions. This information is available from an investigative follow-up report done by the law enforcement agency.

Of the **24** domestic violence fatality reports reviewed for the **2005** reporting period, an active injunction was filed on the perpetrator in **8%** of the cases; previous injunctions had been present in **29%** of the cases and in **one** case an injunction was denied due the decedent's failure to attend the preliminary hearing. The decedents had **three** previous injunctions filed at the time of the fatality.

INJUNCTION HISTORY OF PERPETRATOR	2003	2004	2005
Active injunction	7	8	**2**
Previous injunction	13	5	**7**
Injunction denied	1	0	**1**
Expired injunction	0	0	**0**
Unknown	0	1	**0**

INJUNCTION HISTORY OF DECEDENT	2003	2004	2005
Active injunction	2	1	**0**
Previous injunction	3	1	**3**
Unknown	0	3	**0**

DECEDENT INFORMATION - This information is related to the decedent of the offense. This information is available through law enforcement investigative reports, possible service agency reports, medical examiner reports, newspaper accounts and personal interviews with persons that knew the decedent.

Of the **29** domestic violence fatalities reviewed for the **2005** reporting period, **83%** of the victims were female. The marital status indicated that **7** of the victims were married to the perpetrator. The racial breakdown of the cases reflected that **59%** of the victims were white. A total of **38%** of the decedents were employed at the time of their death. The decedents had **16** non-violent arrests, **three** domestic violence arrests and **three** arrests for other violent crimes. Police had responded to the residence for some reason in **11** cases. The decedent was the victim of another crime **six** times and had been the victim of previous domestic violence with a different partner **five** times. In **15** cases, others had knowledge of domestic violence in the life of the decedent.

Sex

Of the **24** cases reviewed for the **2005** reporting period **four** had multiple victims resulting in a total of **29** decedents. Of the **29** decedents, **24** were female **(83%)**, **four** were male **(14%)** and **one** was a unborn child **(3%).**

Race

Of the **29** decedents, **17** were White **(59%)**, **11** were Black **(38%)** and **one** was from the Dominican Republic (**3%).**

DECEDENT MARITAL STATUS	2003	2004	2005
Never married	12	17	**8**
Widowed	4	2	**1**
Not applicable *(decedent is a child)*	5	6	**2**
Married to perpetrator	17	14	**7**
Married to other	7	5	**3**
Separated from perpetrator	6	5	**4**
Divorced from perpetrator	5	3	**0**
Divorced from other	7	5	**3**
Unknown	0	0	**1**

"Not applicable" includes one unborn child in the 2005 reporting period.

DECEDENT EMPLOYMENT STATUS	2003	2004	2005
Employed	36	23	**11**
Unemployed	8	12	**4**
Retired	7	4	**3**
Not applicable *(decedent is a child)*	4	6	**2**
Unknown	12	13	**9**

"Not applicable" includes one unborn child in the 2005 reporting period.

DECEDENT CRIMINAL HISTORY*	2003	2004	2005
Non-violent crime arrest(s)	8	16	**16**
Domestic violence crime arrest(s)	4	8	**3**
Other violent crime arrest(s)	4	4	**3**

***Note: The Decedent Criminal History category contains multiple selection fields and the review forms may contain more than one response for these categories.**

DECEDENT OTHER RELATED HISTORY*	2003	2004	2005
Documented police response(s) to residence	22	25	**11**
Victim of other offense(s)	11	8	**6**
Previous incidents of domestic violence with different partner(s)	8	7	**5**
History of domestic violence known to other(s)	36	30	**15**

***Note: The Decedent Other Related History category contains multiple selection fields and the review forms may contain more than one response for these categories.**

PERPETRATOR INFORMATION - This information is related to the perpetrator of the fatality. This information is available through law enforcement investigative reports, possible service agency reports, medical examiner reports, newspaper accounts and personal interviews with persons that knew the perpetrator.

Of the **24** domestic violence fatality reports reviewed for the **2005** reporting period, **92%** of the perpetrators were male. The marital status indicated that **29%** of the perpetrators were married to the decedent at the time of the fatality. The racial breakdown of the cases reviewed reflected **50%** of the perpetrators were White. A total of **54%** of the perpetrators were employed at the time of the fatality. The perpetrators had **16** non-violent arrests, **13** domestic violence arrests and **12** arrests for other violent crimes. The perpetrator had a previous domestic violence incident with a different partner in **seven** cases; in **seven** cases, previous domestic violence charges against the perpetrator were dismissed. Known incidents of prior child abuse were reported in **four** cases. In **all** of the cases either drugs, alcohol or medication were present. In **19** of the cases reviewed, other entities had knowledge of domestic violence in the life of the perpetrator.

Sex

There were a total of **24** perpetrators contained in the **24** domestic fatality reports reviewed for the **2005** reporting period. Of the **24** perpetrators **2** were female **(8%)** and **22** male **(92%).**

Race

Of the **24** perpetrators, **12** were White **(50%)**, **11** were Black **(46%)** and **one** Asian/Pacific Islander **(4%).**

PERPETRATOR MARITAL STATUS	2003	2004	2005
Never married	14	21	**11**
Widowed	2	0	**0**
Not applicable *(decedent is a child)*	1	0	**0**
Married to decedent	17	14	**7**
Married to other	1	1	**2**
Separated from decedent	5	5	**4**
Separated from other	0	2	**0**
Divorced from decedent	6	3	**0**
Divorced from other	6	7	**0**
Unknown	8	0	**0**

PERPETRATOR EMPLOYMENT STATUS	2003	2004	2005
Employed	26	28	**13**
Unemployed	13	10	**7**
Retired	8	2	**1**
Unknown	13	13	**3**

PERPETRATOR CRIMINAL HISTORY*	2003	2004	2005
Non-violent crime arrest(s)	23	31	**16**
Domestic violence crime arrest(s)	17	21	**13**
Other violent crime arrest(s)	13	19	**12**
Unknown	0	2	**0**

***Note: The Perpetrator Criminal History category contains multiple selection fields and the review forms may contain more than one response for these categories.**

PERPETRATOR OTHER RELATED HISTORY*	2003	2004	2005
Previous incidents of domestic violence with different partner	14	6	**7**
Previous history of suicide attempt	0	5	**4**
Known allegations of stalking	9	11	**6**
Previous participation in batterer's intervention program	0	2	**3**
Previous abuse of drugs	16	18	**9**
Previous abuse of alcohol	25	28	**12**
Under medication	12	7	**3**
Appeared in court for domestic violence offense	12	14	**12**
Domestic violence related charges were dismissed against the perpetrator	8	7	**7**
History of domestic violence known to other entities	37	30	**19**
Known incidents of prior child abuse	6	6	**4**
Suspected or charged in death of former intimate partner	0	0	**1**
Former intimate partner died in accident/mysterious manner	0	0	**1**
Other	7	0	**0**

***Note: The Perpetrator Other Related History category contains multiple selection fields and the review forms may contain more than one response for these categories.**

PERPETRATOR AS A BATTERED VICTIM - This information is collected in the event the perpetrator is the victim of a domestic violence battery by the decedent, e.g., the victim kills the batterer. This is available from the law enforcement agency's investigative report.

PERPETRATOR KILLED BATTERER	2003	2004	2005
	1	3	**0**

PERPETRATOR SUICIDE - This information is collected in the event the perpetrator of the fatality commits suicide as a part of the incident. This will be available through the law enforcement agency's investigative report.

CAUSE OF DEATH	2003	2004	2005
Gunshot	21	18	**3**
Hanging	0	3	**0**
Drowning	0	0	**1**
Stabbing	0	0	**1**
Smoke inhalation	0	0	**1**
Other	7	0	**0**
Total	**28**	**21**	**6**

SUICIDE NOTE	2003	2004	2005
Suicide note left	12	8	**0**
Suicide appeared to be part of the homicide	15	15	**4**
Suicide separate and distinct incident from fatality	13	6	**2**

RELATIONSHIP ISSUES - This information explains the relationship between the decedent and the perpetrator of the fatality. This is available from the law enforcement agency's investigative report.

Of the **29** domestic fatalities reviewed for the **2005** reporting period, the victim in **34%** of the fatalities was the spouse or ex-spouse of the perpetrator and in **41%** of the fatalities the victim was the ex-girlfriend, co-habitant or ex-co-habitant of the perpetrator. Prior threats to kill the decedent occurred in **38%** of the fatalities. Previous incidents of domestic violence had been reported in **45%** of the fatalities. A significant change in the relationship between the decedent and perpetrator had occurred in **59%** of the fatalities.

Regarding the **29** domestic violence fatalities reviewed for the **2005** reporting period, the categories of spouse, ex-girlfriend, co-habitant and ex-cohabitant made up **76%** of the relationships involved in the fatalities.

DECEDENT RELATIONSHIP TO PERPETRATOR	2003	2004	2005
Spouse	22	19	**10**
Ex-spouse	5	3	**0**
Parent	9	2	**3**
Step parent	0	0	**0**
Child	4	5	**2**
Step child	0	0	**0**
Boyfriend	2	1	**0**
Ex-boyfriend	0	0	**0**
Child of boyfriend	0	0	**0**
Brother/Sister	1	0	**0**
In-law	0	2	**1**
Co-habitant	7	10	**7**
Ex-cohabitant	0	12	**4**
Girlfriend	8	0	**0**
Ex-girlfriend	6	0	**1**
Child of girlfriend	0	0	**0**
Other *(known)*	3	6	**1**
Total	**67**	**60**	**29**

"Child" includes one unborn child in the 2005 reporting period.

"Other Known" comprises one bystander (roommate, possible girlfriend of the decedent) in the 2005 reporting period.

PRIOR THREATS TO DECEDENT BY PERPETRATOR*	2003	2004	2005
Threat to kill decedent	25	12	**11**
Threat to kill children or family member	7	3	**2**
Threat to commit suicide	9	8	**8**
Other	1	3	**4**

***The Prior Threats to Decedent by Perpetrator category contains multiple selection fields and the review forms may contain more than one response for these categories.**

Regarding the 24 domestic violence fatality reports reviewed for the 2005 reporting period, the category of "Other" consists of one threat to decedent's new boyfriend, one threat to kill decedent's new intimate partner, one threat to disfigure the decedent and one threat to take the children.

RELATIONSHIP ISSUES*	2003	2004	2005
They lived together at some point	42	23	**26**
They lived together at the time of the fatality	31	28	**18**
They were intimate prior to the fatality	12	10	**6**
They had a child(ren) in common	19	13	**7**
They had a child(ren) in the household, but not in common	12	5	**6**
They always maintained separate dwellings	2	1	**1**
They had previous reported incidents of domestic violence	24	23	**13**
They had a significant change in the relationship	36	28	**17**

***Note: The Relationship Issues category contains multiple selection fields and the review forms may contain more than one response for these categories.**

CONTRIBUTING FACTORS TO THE INCIDENT - This information concerns the factors that may have contributed to the violence escalating to the point where a homicide occurred. The factors are given a numerical rating by the review teams, with a rating of one being the major contributing factor; the greater the numerical rating the less it contributed to the fatality. This information is available through law enforcement investigative reports, possible service agency reports, medical examiner reports, newspaper accounts and interviews with persons that knew the perpetrator and/or decedent.

The **three** major contributing factors to the fatalities identified by the Domestic Violence Fatality Review Teams were: **1)** Decedent and Perpetrator in process of separation at time of fatality **2)** Perpetrator had/has abused alcohol and **3)** Perpetrator alleged to have committed act to avenge a perceived wrongdoing by decedent. In **62%** of the reviewed fatalities, a separation was taking place or had already taken place in the relationship.

Major Contributing Factors To The Fatalities were:

(the following factors were given a priority rating of one, two or three by team members)

1) Decedent and perpetrator in process of separation at time of fatality - **eight** times.
2) Perpetrator had/has abused alcohol – **seven** times.
3) Perpetrator alleged to have committed act to avenge a perceived wrongdoing by decedent - **seven** times.
4) Decedent had started a new relationship – **six** times.
5) Decedent and perpetrator had separated – **five** times.
6) Perpetrator had/has abused drugs, Decedent had/has abused alcohol, Perpetrator had/has mental health problems and the category of other were each reported **four** times. (Other: dispersement of money during separation, mother-in-law complained about kids, upset with decedent and upset over no contact order.)

ESCALATING CIRCUMSTANCES - This information relates to the circumstances surrounding the fatality that might have caused the level of violence to escalate to the point where a homicide occurred. It also addresses the awareness that the violence was increasing in the relationship. This information is available through law enforcement investigative reports, possible service agency reports, medical examiner reports, newspaper accounts and personal interviews with persons that knew the perpetrator and/or decedent.

The three escalating circumstances that occurred most for the decedent were: 1) Exhibit signs of depression, anger, low self esteem and suicidal thoughts **2)** Express fear of physical danger to themselves and/or child(ren) **3)** Have evidence of physical injury.

ESCALATING CIRCUMSTANCES (DECEDENT)*	2003	2004	2005
Express fear of physical danger to themselves and/or children	29	22	**11**
Express fear of losing custody of children	2	3	**2**
Isolate themselves from family and friends	8	4	**1**
Have evidence of physical injury	19	10	**8**
Exhibit signs of: depression, anger, low self esteem, suicidal thoughts	24	21	**12**
Express fear of involvement in the criminal justice system process	5	0	**1**
Show or express signs of sleeping difficulties	1	0	**1**
Express guilty feelings about the failed relationship	6	1	**1**
Show or express history of familial abuse	9	4	**0**
Express fear of being alone	3	1	**1**
Express fear of making a great life change	5	0	**2**
Express belief that perpetrator would change and/or stop abusive behavior	5	2	**2**

***The Escalating Circumstances Decedent category contains multiple selection fields and the review forms may contain more than one response for this category.**

The three escalating circumstances that occurred most for the perpetrator were: 1) Use intimidation by instilling fear through looks and gestures **2)** Abuse the decedent in public and **3)** Keep tabs on or stalk the decedent.

ESCALATING CIRCUMSTANCES (PERPETRATOR)*	2003	2004	2005
Abuse the decedent in public	6	8	**6**
Keep tabs on or stalk the decedent	19	12	**6**
Put down the decedent's friends and family	13	6	**2**
Tell the decedent, jealousy is a sign of love	3	1	**1**
Make all decisions in the relationship (including finances)	7	8	**2**
Blame decedent for abuse	10	2	**4**
Use intimidation by instilling fear through looks and gestures	13	7	**7**
Smash objects and destroy property	11	7	**5**
Tell the decedent their fears about the relationship were not important	1	0	**1**

***The Escalating Circumstances (Perpetrator) category contains multiple selection fields and the review forms may contain more than one response for this category.**

SERVICES REQUESTED, ORDERED OR OBTAINED - This information relates to the decedents' and perpetrators' interactions with services, legal aid and medical organizations as they related to the domestic violence issues prior to the fatality. This information is available through the actual agency logs and service records maintained by the individual entities. Some of this information may also be available through interviews of persons that knew the perpetrator or decedent.

Services Requested, Ordered or Obtained						
	2003		2004		2005	
	Decedent	Perpetrator	Decedent	Perpetrator	Decedent	Perpetrator
Domestic Violence Services						
Requests/Orders for service	12	0	6	4	**4**	**2**
Services provided	12	1	6	2	**3**	**2**
Criminal Justice Legal						
Requests/Orders for service	59	26	45	46	**23**	**15**
Services provided	57	39	51	60	**33**	**45**
Health Care Provider						
Requests/Orders for service	16	17	10	13	**4**	**3**
Services provided	10	12	11	13	**16**	**12**
Children/Family Services						
Requests/Orders for service	3	4	7	3	**2**	**2**
Services provided	2	2	6	3	**5**	**5**

Some of the fatality review cases revealed that on occasion more services were provided than were requested or ordered for the decedent and/or perpetrator. *Note: this can occur when services are offered/provided in accordance with a statutory requirement or a court order.*

In cases where a minor and/or dependent child was present during the fatality, children/family services were requested for the child(ren) **nine** times and provided **16** times in **2005**, requested and provided **seven** times in **2004** and requested **three** times and provided **two** times in **2003.**

LETHALITY INDICATORS – These factors have been identified based on previously studied domestic violence fatalities and focus on elements considered to be the most prevalent in domestic homicides. This information is available through law enforcement investigative reports, possible service agency reports, medical examiner reports, newspaper accounts and personal interviews with persons that knew the perpetrator and decedent.

Decedents' Emotional / Mental Deterioration*	***2003***	***2004***	***2005***
Suicidal	3	1	**2**
Homicidal	1	3	**0**
Loss of day to day function	2	0	**0**
History of psychiatric problems	3	2	**0**
Poor compliance with taking medication	2	1	**0**
Depression	5	7	**3**
Economic loss	3	2	**3**
Loss of family support	2	1	**3**

Perpetrators' Emotional / Mental Deterioration*	***2003***	***2004***	***2005***
Suicidal	24	24	**12**
Homicidal	34	26	**14**
Loss of day to day function	8	2	**4**
History of psychiatric problems	8	2	**3**
Poor compliance with taking medication	4	1	**1**
Depression	15	13	**5**
Economic loss	16	4	**5**
Loss of family support	7	3	**2**

Decedents' Antisocial Behavior*	***2003***	***2004***	***2005***
History of domestic violence	8	9	**3**
History of assaults on others	7	5	**2**
History of criminal activity	7	8	**6**
History of stalking	1	2	**0**
History of substance abuse	10	15	**8**
Possession of weapons	3	3	**3**
History of abusing children*(physically and/or sexually)*	2	2	**2**
History of childhood abuse or witnessing violence	2	5	**0**

Perpetrators' Antisocial Behavior*	***2003***	***2004***	***2005***
History of domestic violence	35	30	**17**
History of assaults on others	20	18	**10**
History of criminal activity	22	22	**15**
History of stalking	14	14	**6**
History of substance abuse	22	31	**13**
Possession of weapons	33	28	**10**
History of abusing children*(physically and/or sexually)*	4	6	**4**
History of childhood abuse or witnessing violence	3	1	**1**

*Decedents' Failure of Community Control**	*2003*	*2004*	*2005*
Violation(s) of restraining order	3	1	**1**
Violation(s) of probation	2	2	**3**
Arrest(s) for domestic violence	4	6	**2**
Failure to complete batterer's intervention program	2	1	**0**
Failure to complete substance abuse treatment	2	0	**1**
Failure to complete anger management program	1	1	**0**

*Perpetrators' Failure of Community Control**	*2003*	*2004*	*2005*
Violation(s) of restraining order	5	4	**2**
Violation(s) of probation	4	6	**4**
Arrest(s) for domestic violence	8	10	**9**
Failure to complete batterer's intervention program	0	3	**4**
Failure to complete substance abuse treatment	0	0	**1**
Failure to complete anger management program	1	0	**1**

*Decedents' Severity of Violence**	*2003*	*2004*	*2005*
Used a Weapon	3	2	**2**
Death threat	2	3	**1**
Unwanted sexual contact	0	0	**0**
Strangulation	0	0	**0**
Hurt pet	0	0	**0**
Severe injury	4	0	**1**
Sadistic / Threatening act	0	2	**0**
Expressed concerns that she / he would be killed	17	11	**8**

*Perpetrators' Severity of Violence**	*2003*	*2004*	*2005*
Used a weapon	41	21	**9**
Death threat	26	12	**8**
Unwanted sexual contact	1	2	**2**
Strangulation	6	4	**2**
Hurt pet	1	0	**0**
Severe injury	16	8	**1**
Sadistic / Threatening act	8	5	**3**
Expressed concerns that she / he would be killed	1	2	**0**

*Decedents' Ownership / Centrality of Decedent to Perpetrator**	*2003*	*2004*	*2005*
Obsessiveness about partner or family	2	2	**0**
Extreme jealousy	3	1	**0**
Access to victim and/or family members	4	2	**1**
Rage and/or depression over separation	2	0	**0**
Perceived betrayal	7	2	**1**
Perceived rejection after attempt to reconcile	1	0	**0**

*Perpetrators' Ownership / Centrality of Decedent to Perpetrator**	*2003*	*2004*	*2005*
Obsessiveness about partner or family	23	18	**11**
Extreme jealousy	24	14	**12**
Access to victim and/or family members	29	21	**11**
Rage and/or depression over separation	24	19	**9**
Perceived betrayal	28	17	**12**
Perceived rejection after attempt to reconcile	9	11	**9**

***Lethality Indicators (Decedent and Perpetrator) categories contain multiple selection fields and the review forms may contain more than one response for these categories.**

FATALITY REVIEW TEAMS SUMMARY - This portion of the data collection process allows the Domestic Violence Fatality Review Team to summarize their overall findings and recommendations that relate to the specifically reviewed domestic violence fatality. This information is derived from a careful analysis of the information available during the review.

INDICATIONS THAT ABUSE WAS INCREASING	2003		2004		2005	
	VOLUME	%	VOLUME	%	VOLUME	%
Yes	36	60%	29	55%	**12**	**50%**
No	10	17%	18	34%	**8**	**33%**
Unknown	2	3%	1	2%	**4**	**17%**
No information provided	12	20%	5	9%	**0**	

ENTITIES WITH KNOWLEDGE OF ABUSE*	2003	2004	2005
Law Enforcement	15	26	**11**
Family	31	28	**15**
Acquaintance/Neighbor	11	11	**8**
State/County	16	20	**7**
Employer/Co-worker	6	2	**7**
Abuse center/Shelter	2	2	**1**
Military	1	0	**0**
Friends	18	18	**11**
Medical	0	1	**0**
No known entities had knowledge of abuse	14	0	**7**
No information provided	0	12	**0**

*** Entities With Knowledge of Abuse category contains multiple selection fields and the review forms may contain more than one response for this category.**

Appendix A

Domestic Violence Fatality Review Teams Annual Summary Evaluations Submitted to FDLE for 2005

TEAM: BAY COUNTY FATALITY REVIEW TEAM **YEAR: 2005**
NAME OF CONTACT: LORNE BROOKS **PHONE: (850) 747-3234**

1) What are the most significant findings from your review(s)?

- Although all sorts of services are available to victims in our county, law enforcement and service providers cannot force victims to utilize readily available services.

2) What changes in policy or procedure (if any) were made as a result of your review?

- In mid-2004, the Bay County Sheriff's Office established a Domestic Violence Unit to provide better services for victims and pursue cooperative efforts with other local law enforcement agencies, as well as other service providers.

  2a) Where did they occur?
  The Bay County Sheriff's Office extending out to other law enforcement agencies, and including participation by the State Attorney's Office.

  2b) How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?
  Formal and informal, depending on the agency.

3) What change(s) in law, policy or procedure (if any) does your team recommend for consideration at the state level?

- Arrest for domestic violence with a previous battery conviction of any kind should bump the newest charge to a felony, as opposed to the decision being made by officer discretion.

4) Additional comments or concerns.

- Please add a section for tracking of animal or pet involvement in the domestic fatality rather than tracking past history. Many of our cases involved the vicious murder of the family pet and the current forms do not encourage tracking this important information.

TEAM: __BREVARD COUNTY FATALITY REVIEW TEAM **YEAR: 2005**
NAME OF CONTACT: GENNY BUSSEN **PHONE: (321) 632-5792**

1) What are the most significant findings from your review(s)?

- Intergenerational Circe of Violence continues.
- No substance or mental health treatment available
- No family (out reach) awareness services.
- Gap of services for At Risk Children. i.e., DCF, School

2) What changes in policy or procedure (if any) were made as a result of your review?

- Open dialogue with courts to resolve issues regarding restraining orders.
- Addressed issues of publishing names of victims in news paper prior to civil hearings.

2a) Where did they occur?
Brevard County Misdemeanor Probation

2b) How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?
Memos of awareness, Zero Tolerance Policy between circuit court system and Salvaton Army for the victims.

3) What change(s) in law, policy or procedure (if any) does your team recommend for consideration at the state level?

- Looking at any civil procedures being published in news papers regarding domestic violence and/or dating violence.
- Send Fatality Review reports to law makers so they can see why more information and funding for domestic violence services are needed.

4) Additional comments or concerns.

- Fatality Review Teams are concerned about funding, i.e., grants being reduced or taken away for domestic violence services.

TEAM: BROWARD COUNTY FATALITY REVIEW TEAM **YEAR: 2005**
NAME OF CONTACT: NANCY TANNER **PHONE: (954) 765-4133**

1) What are the most significant findings from your review(s)?

- Victim Safety would benefit from the availability of a counseling service explaining the implications of their decision for individuals contemplating divorce. (January 2004)
- Victim Safety would benefit from the delivery of information regarding safety issues exacerbated by divorce/separation and the propensity for domestic violence with this decision. (Amended April 2004)
- Community and victim safety would benefit from the understanding that the likelihood of domestic violence increases dramatically at times of separation/divorce. To facilitate this understanding, therapists, attorneys, clergy and other community professionals who are consulted in this process, should provide safety information to individuals contemplating or pursuing separation/divorce. (Amended September 2004)

2) What changes in policy or procedure (if any) were made as a result of your review?

- The Broward Chiefs of Police Association will consider the adoption of Uniform Protocols for Police Based Victim Advocates presented by the Broward Domestic Violence Council at its May meeting.(Accepted at May 2005 meeting)

  2a) Where did they occur?
  All Broward county police agencies will be expected to follow these protocols when responding to cases of domestic violence.

  2b) How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?
  The BDVFR (Broward Domestic Violence Fatality Review) team presented the recommendation to the Broward Domestic Violence Council and two members of the team worked with an ad hoc committee to develop recommendations for presentation to the Broward Chiefs of Police Association. The Council President presented the findings to the Chiefs at their regular meeting and their feedback was incorporated into the document. The amended protocol was presented to the Chiefs at their May meeting.

3) What change(s) in law, policy or procedure (if any) does your team recommend for consideration at the state level?

- Victim safety would benefit from domestic violence providers, law enforcement and judicial access to a centralized database containing civil and criminal case information.

4) Additional comments or concerns.

- The Broward Domestic Violence Fatality Review Team suspended case reviews last spring to reassess the community response to its findings. The Team set out at that time to shepherd the findings to an agency or organization with a vested interest in their implementation.
- This exercise was helpful because it gave the team an opportunity to look at the difficulty of implementing some changes due to the way the recommendations were written. This undertaking was also helpful because it gave team members an opportunity to find agencies and organizations to foster the success of their recommendations. These linkages enhance the quality of future reviews.
- The team never expected that it would have to follow up with the implementation of its recommendations once they were delivered. It learned, however, that its efforts were futile otherwise. Without staff coordination or an oversight agency to steward the findings they are merely words in the Governor's Annual Report.

TEAM: MIAMI DADE COUNTY FATALITY REVIEW TEAM **YEAR: 2005**
NAME OF CONTACT: LAUREN LAZARUS, ESQ. **PHONE: (305) 349-5555**

1) What are the most significant findings from your review(s)?

Quantitative findings

- The Miami-Dade County Domestic Violence Fatality Review Team reviewed a total of 24 cases in the year 2004. One case was declared a justifiable homicide, and for the purposes of statistical analysis has not been included in this data set.

- The review found that gunshot wounds were the leading cause of death for the majority of domestic violence -related homicide cases that were reviewed (63%).

- In 66% of the cases reviewed, the Decedent had been a victim of domestic violence by the Perpetrator prior to the fatal incident.

- In 46% of the cases reviewed, records indicated that the Perpetrator had a history of substance abuse.

- The review found that in 58% of the cases reviewed, the Decedent and Perpetrator were separated at the time of the fatal incident.

- In 54% of the cases reviewed, the Perpetrator was found to have a history of criminal activity.

- In 50% of the cases reviewed, records indicated that the Perpetrator engaged in prior deaths threats towards the Decedent.

- In 54% of the cases reviewed, the Perpetrator committed suicide at the time of the fatal incident.

- Of the cases reviewed, 12 had children residing in the household. Of those 12, 5 witnessed the fatal incident, either visually of by earshot, and in 1 case, the child was the second homicide victim.

- The review revealed that community awareness regarding ownership/centrality issues, which include obsessiveness about partners and/or families, as well as excessive jealousy, as prominent lethality indicators, continues to be necessary.

- The review revealed that many victims' lifestyles do not allow for a support system to be present, therefore, an domestic violence awareness campaign targeting the homeless, sex workers, and drug/alcohol abusers, is needed in the community.

MIAMI DADE COUNTY FATALITY REVIEW TEAM – continued

- The review revealed that there is no mechanism in place to assess suicidality in family members of the terminally ill. Research indicates that elderly men, especially those that suffer from a medical condition, are at a high risk for committing suicide. Further, the risk is compounded for those who feel alone, or have added stressors, such as caring for a terminally ill partner. For this reason, the review team recommends that healthcare professionals be trained to identify these risk factors, assess for suicide, and proceed to initiate referrals for intervention. Additionally, implementing a case management practice to respond to these cases would benefit the community.

- The review team repeatedly found that educational awareness of death threats as a predominant lethality indicator should be a training topic to focus upon throughout the community. Additionally, educational awareness of stalking as a predominant lethality indicator is needed.

- The review found that reports regarding domestic violence calls need to be written by patrol officers in accordance with Florida Statutes.

- Currently, the Miami-Dade County Police Department's Domestic Crimes Bureau has developed a brochure outlining appropriate responses by patrol officers to domestic violence calls. This brochure has a section regarding responding to calls involving officers as subjects. The review found that this or a similar brochure should be adopted by all police agencies throughout the county and State.

- The review found that it is necessary for all local municipalities to adopt uniform procedures for the standard practice of notification from responding agencies to concerned agencies in any domestic violence-related incident, either criminal or non-criminal.

- The review revealed that continued public awareness is needed regarding calling police when hearing neighbors in distress and that within this campaign, cultural issues that may hinder intervention in these cases be addressed.

- The review revealed that currently there is no batterers' treatment program in place in the jails for domestic violence offenders. A mandatory batterers' intervention program while in custody is an important public safety intervention.

- The review revealed that public awareness which targets cultural differences and the dynamics of domestic violence would be beneficial to the community and victims of domestic violence.

MIAMI DADE COUNTY FATALITY REVIEW TEAM – continued

- The review revealed that the mental health system is in need of continued training in lethality indicators and risk assessment. Additionally, there is a need for resources to intensively treat high risk cases, and effectively follow-up on patients after their release from a crisis center or hospital for continued treatment and medication management.

- The review revealed that the majority of law enforcement agencies do not have victim advocates assigned to their homicide units. Additionally, many agencies do not have advocates assigned to domestic violence because of lack of funding. However, the review found that the services provided by these advocates are essential to victims and surviving family members.

- The review revealed that all city and county workers should be trained regarding domestic violence in the workplace and their obligation to assist victims by calling law enforcement when witnessing a domestic violence incident.

2) What changes in policy or procedure (if any) were made as a result of your review?
2a) Where did they occur?
2b) How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?

- Continued lethality training within the justice system and associated community social service agency providers throughout the year.

- The DV Review Team implemented a procedure whereby all related agencies are immediately notified of all domestic violence-related fatality incidents. This allows for an expedited response to surviving family members, as well as an immediate internal review of policies and procedures by each respective agency. In one of the cases reviewed, this system resulted in the improvement of communication between the Court, the County's misdemeanor probation office, and treatment providers. Further, policies were immediately amended to improve the provision for the monitoring and treatment of batterers.

- The review process has encouraged the local Department of Children and Families office and different law enforcement agencies to work together and set up formal policies and procedures when both agencies are investigating the same family.

- The review process has prompted systematic change through the intensive review of each domestic violence fatality case within a multi-disciplinary setting. Examples of these changes include several policies and procedures which have been instituted by multiple justice systems and community agencies. One such example is the implementation of lethality assessment by local law enforcement responding to domestic violence incidents. In these such cases, the presence of a death threat is viewed as a risk factor and police respond accordingly.

3) What change(s) in law, policy or procedure (if any) does your team recommend for consideration at the state level?

- The DV Review Team recommends a statewide educational awareness campaign on lethality indicators and the cycle of violence. Additionally, all state certified batterers' intervention program treatment providers should receive continued culturally competent training on these issues.

- The DV Review Team recommends that a batterers' intervention program be implemented in the jail/prison system and becomes mandatory for all domestic violence offenders while in custody.

4) Additional comments or concerns.

- The review team feels that state funding to support the fatality review process is needed throughout the State.

TEAM: DUVAL COUNTY FATALITY REVIEW TEAM **YEAR: 2005**
NAME OF CONTACT: LIBBY SENTERFITT **PHONE: (904) 630-2502**

1) What are the most significant findings from your review(s)?

- There were a large number of elderly victims this year. Fifty-six percent of the victims were 65 years old or older.
- In cases where there were prior arrests for domestic violence none of the perpetrators were referred to a Batterers' Intervention Program..
- Forty-four percent of the suspects had mental health issues
- None of the victims' children were referred to the HARK Program.

2) What changes in policy or procedure (if any) were made as a result of your review?

- This Committee continues to support absolute statutory compliance by sending perpetrators of domestic violence to certified Batterers' Intervention Programs.

2a) Where did they occur?
N/A

2b) How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?
N/A

3) What change(s) in law, policy or procedure (if any) does your team recommend for consideration at the state level?

- Mandatory judicial training on issues of domestic violence.

4) Additional comments or concerns.
None

TEAM: __LEE COUNTY FATALITY REVIEW TEAM **YEAR: 2005**
NAME OF CONTACT: NICA BOBACK **PHONE (239)335-2140**

1) What are the most significant findings from your review(s)?

- In most cases mental health issues played a large part in the fatalities.
- There is also a need for more education and awareness to the public on domestic violence issues.

2) What changes in policy or procedure (if any) were made as a result of your review?
None

2a) Where did they occur?
N/A

2b) How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?
N/A

3) What change(s) in law, policy or procedure (if any) does your team recommend for consideration at the state level?

- More funding for mental health issues and programs.
- More funding for domestic violence programs.
- More community education on domestic violence.
- More mandatory training for law enforcement, judges and legal professionals

4) Additional comments or concerns.
None

TEAM: PALM BEACH COUNTY FATALITY REVIEW TEAM **YEAR: 2005**
NAME OF CONTACT: CYNTHIA RUBENSTEIN **PHONE: (561)706-1004**

1) What are the most significant findings from your review(s)?

- One of the cases was in a state of separation.
- Two of the cases involved substance abuse/use.
- One of the cases involved the homicide of a handicapped person.
- Two of the cases had no prior history of domestic violence between the decedents and the perpetrator.
- One case involved a possible violation of confidentiality/policy failure regarding a law clerk providing information to a respondent, which appeared to be a significant reason the homicide occurred.
- Two of the perpetrators had prior criminal history.
- Children were involved in all three cases, being injured in one, present at prior domestic violence incidents in one, and witnessing the preparation of the weapon in one case.
- One of the perpetrators has a history of child abuse.
- Three cases involved the perpetrator committing suicide.
- There were various methods used to commit the fatalities. Two cases involved stabbings and one a shooting.
- All three cases had multiple decedents.
- A need for training between the domestic violence and substance abuse disciplines were seen during these reviews.
- Probation violations are in question in one of the cases.

2) What changes in policy or procedure (if any) were made as a result of your review?

- The team hosted this year's Annual National Fatality Review Team Conference. Two team members spoke at this conference.
- All participating agencies of the team continue to do agency internal and external trainings to various organizations and agencies to provide information on the team's findings.
- The team has continued to respond to local newspapers in response to insensitive articles written on domestic violence cases. These responses are written to educate the editors and readers on the dynamics of domestic violence that contribute to domestic violence fatalities.
- Surviving family members continue to be linked with needed services as a result of the work of the team.

2a) Where did they occur?
N/A

2b) How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?
N/A

3) What change(s) in law, policy or procedure (if any) does your team recommend for consideration at the state level?

- Habitualization of convicted domestic violence perpetrators. This is taking into account any pre-trial diversion programs for domestic violence.
- Increase funding so the domestic violence fatality review teams can have support staff in this important endeavor.
- A standard for probation that will ensure timely referrals to court-ordered resources, competent follow-up by probation officers to ensure that services are being followed and timely violations of probation when court-ordered sanctions are not completed.
- Mandated interdisciplinary training for professionals working within the substance abuse and domestic violence communities to ensure personnel interface between the two treating entities.
- Increase funding to mandate local law enforcement to employ victim advocates in every law enforcement agency.

4) Additional comments or concerns.

- This team continues to value our approach of reviewing each case in depth, including speaking to family members. We feel we put a human face to the case and not just report statistics.
- The continued supportive outreach network created by the team members while working in the community encourages community members to reach out for assistance when they suspect cases of domestic violence within their own communities.
- The strong supportive network created by the team members assists in the prevention of compassion fatigue and burnout.
- In addition to policy changes, the work of the team has produced results that while not necessarily quantifiable are equally important.

TEAM: PINELLAS COUNTY FATALITY REVIEW TEAM **YEAR: 2005**
NAME OF CONTACT: FRIEDA A. WIDERA **PHONE: (727)586-7481**

1) What are the most significant findings from your review(s)?

- Substance use/abuse continues to be a problem in many cases.
- Friends/family/coworkers often know about violence but do not know how to intervene.
- Higher incidence of cases that had prior domestic violence history than prior years' reviews.

2) What changes in policy or procedure (if any) were made as a result of your review?

- Two brochures were created that address friends/family of domestic violence victims or perpetrators and seniors impacted by domestic violence.

  2a) Where did they occur?
  Distributed to Domestic Violence Task Force members to disseminate throughout the community.

  2b) How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?
  N/A

3) What change(s) in law, policy or procedure (if any) does your team recommend for consideration at the state level?

- Continued lethality training within legal system, probation, and social service providers.
- Increased education and awareness about the high percentage of domestic related fatalities that involve a firearm.
- Due to high incidence of substance use, share findings with substance abuse professionals and encourage continued education on the dynamics of domestic violence.

4) Additional comments or concerns.

- Our community has not been successful in addressing all of the recommendations our team has made. Limited resources continues to be an issue.
- We hope to address and implement more of the team's recommendations through committees of our local Domestic Violence Task Force.

TEAM: POLK COUNTY FATALITY REVIEW TEAM **YEAR: 2005**
NAME OF CONTACT: CHERIE SIMMERS **PHONE: (863)534-4173**

1) What are the most significant findings from your review(s)?

- Use of a firearm was a common factor in many cases.
- At the scene of the crime (where the decedent resided) drug and/or alcohol abuse by the perpetrator and sometimes by the decedent was apparent in a majority of the cases.
- In all the cases, other people, such as family, neighbors or co-workers knew of the escalating violence and threats from the perpetrator to either harm the victim or himself.
- All the perpetrators were men.
- All of the men exhibited over 10 of the lethality factors listed on the reporting instrument with the highest numbers in the "ownership/centrality" of decedent to perpetrator category.
- The most significant finding is the system's ineffectiveness when dealing with complex relationship issues.
- All parts of the system followed procedure without fail.
- Many times the victim appeared to not recognize the high risk of lethality until only a short time prior to the death.

2) What changes in policy or procedure (if any) were made as a result of your review?

- Our sheriff's office and court created an order with specific instructions for respondents who are required to surrender firearms in injunction for protection cases. We are currently working on some awareness posters.
- Our domestic violence task force is currently working on some informative posters for those filing for injunctions.

2a) Where did they occur?
Domestic violence injunction court and law enforcement.

2b) How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?
Changes occurred through meetings and reaching consensus that resulted in informal agreements.

3) What change(s) in law, policy or procedure (if any) does your team recommend for consideration at the state level?

- Continue funding domestic violence shelters.
- Change language in injunction for protection orders requiring specific instructions for weapons surrender in domestic and dating violence injunction orders.
- Provide follow-up regarding compliance with court ordered firearms surrender in injunction cases as well as criminal cases.
- Create an awareness campaign focusing on available resources for domestic violence victims. Insure that resources for victims include safe housing, job training and emotional support

- Create awareness literature that includes the message that "home" is not a safe place to stay when separating from an abusive partner

4) Additional comments or concerns.

- The data submission form could be much more efficient if a database could be created in which the teams could insert information and send form electronically. PLEASE consider this improvement.
- Congratulations on the confidentiality law for fatality review teams that just passed in the recent legislative session!

TEAM: SARASOTA COUNTY FATALITY REVIEW TEAM **YEAR: 2005**
NAME OF CONTACT: JEANIE OCASIO **PHONE: (941)365-0208**

1) What are the most significant findings from your review(s)?

- No information provided

2) What changes in policy or procedure (if any) were made as a result of your review?
None

2a) Where did they occur?
N/A

2b) How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?
N/A

3) What change(s) in law, policy or procedure (if any) does your team recommend for consideration at the state level?

- Perhaps a follow-up in court in all domestic violence injunction cases, three to six months after the initial hearing to see if terms are being carried out.

4) Additional comments or concerns.
None

Appendix B

Profile of Data from 24 Domestic Violence Fatality Team Reviews Submitted to FDLE for 2005

2005 Annual Domestic Violence Fatality Review Profile of Data

Date of Fatality	Decedent'(s)Race Sex & Age	Perpetrator'(s) Race Sex & Age	Decedent's Relationship to Perpetrator	Cause of Death	Domestic Violence History
07/07/2000	Black female; 44	Black male; 47	Co-habitant	Stabbing	Yes
02/18/2000	White female; 52	White male; 51	Spouse	Gunshot	No
	White male; 88	Same as above	Parent	Gunshot	No
	White female; 81	Same as above	Parent	Gunshot	No
09/23/2000	White male; 60	Black female; 48	Spouse	Stabbing	Yes
04/01/2002	Black female; 34	Black male; 40	Co-habitant	Strangulation	Yes
07/06/2004	Black female; 54	Black male; 53	Spouse	Stabbing	Yes
04/09/1994	Black female; 30	Black male; 28	Ex- cohabitant	Gunshot	Yes
09/02/2001	White male; 6	White female; 39	Child	Gunshot	No
07/21/2002	White female; 46	White male; 47	Spouse	Blunt Trauma	Yes
11/18/1992	Black female; 28	Black male; 24	Ex-cohabitant	Gunshot	No
05/22/2003	White female; 56	White male; 41	Spouse	Gunshot	Unknown
06/13/2003	White female; 38	Asian/Pacific male; 60	Spouse	Stabbing	No
	White female; 67	Same as above	In-law	Stabbing	No
07/09/2003	White male; 61	White male; 43	Parent	Gunshot	Unknown
	White female; 30	Same as above	Other	Gunshot	By-stander
07/20/2002	White female; 35	White male; 38	Spouse	Gunshot	Yes
03/07/2002	Black female; 50	Black male; 43	Co-habitant	Stabbing	No
08/03/2002	Black female; 27	Black male; 25	Ex-cohabitant	Strangulation	Yes
06/21/2001	Other female; 44	White male; 54	Spouse	Stabbing	Yes
10/06/1999	Black female; 19	Black male; 27	Ex-girlfriend	Gunshot	Yes
	Black unknown; 1	Same as above	Child *(unborn)*	Other	
09/19/1994	White female; 34	White male; 48	Spouse	Gunshot	Yes
11/04/1996	White female; 52	White male; 62	Spouse	Gunshot	No

2005 Annual Domestic Violence Fatality Review Profile of Data

Date of Fatality	Decedent'(s)Race Sex & Age	Perpetrator'(s) Race Sex & Age	Decedent's Relationship to Perpetrator	Cause of Death	Domestic Violence History
06/26/2001	White female; 39	White male; 39	Co-habitant	Gunshot	No
09/03/2002	White female; 55	White male; 51	Co-habitant	Strangulation	No
02/05/1993	Black female; 31	Black male; 36	Ex-cohabitant	Gunshot	Unknown
02/04/2003	White female; 37	White male; 34	Co-habitant	Strangulation	Yes
10/12/1997	Black female; 38	Black male; 39	Co-habitant	Stabbing	Yes

Appendix C
Legislation 2000 - 2004

Legislation

2000
The Florida Legislature enacted Section 741.316, Florida Statutes, which recognized the work of these teams and called for the Florida Department of Law Enforcement (FDLE) to develop a standard data collection form, to gather information from the local Domestic Violence Fatality Review Teams, and to publish an annual state-level report.

2001
The Florida Legislature approved, and Governor Bush signed into law, the "Family Protection Act" which requires a 5-day mandatory jail term for any crime of domestic battery in which the perpetrator deliberately injures the victim. This law also makes a second battery crime a felony offense, which will effectively treat repeat offenders as serious criminals. The Family Protection Act also requires persons convicted of violent crimes to pay a $201 surcharge to offset the costs of local incarceration and support domestic violence shelters.

2002
The Florida Legislature approved, and Governor Bush signed into law, Senate Bill 716 (s. 741.28, F.S.) which clarifies that people who have a child in common, or who are in a dating relationship, are not required to have resided together to be eligible for an injunction for protection against violence. Senate Bill 716 also eliminates the filing fee for protective orders (s. 741.30, F.S.) and allows certified domestic violence advocates, prosecution, or law enforcement advocates to be present during injunction hearings.

In the state's continuing efforts to reduce domestic violence crimes, Governor Bush initiated Violence Free Florida! in 2002. This program is aimed at reducing domestic violence through greater public awareness of this crime, increasing services for its victims, and providing additional public/private partnerships for greater community involvement in these efforts.

2003
The Florida Legislature approved, and Governor Bush signed House Bill 1099, relating to Domestic Violence Centers. This bill removes the requirement that the Department of Children and Families approve or reject applications for funding received from domestic violence centers; provides for provision of technical assistance and distribution of funds for said centers by a statewide association whose primary purpose is to provide technical assistance to certified domestic violence centers; and provides requirements for contracts between said association and certified domestic violence centers. Since Fiscal Year 1998-99 funding for domestic violence shelters and their services has increased by nearly eighty percent.

2004
There were no bills relating to Domestic Violence Fatality Review Teams, passed in this year's session.

Appendix D

Raw Data from 24 Domestic Violence Fatality Team Reviews Submitted to FDLE for 2005

RAW DATA

The following data is from the cases that were provided to the DVDRC by participating teams. Because the data is from 10 teams covering only 12 counties the reader is cautioned about drawing conclusions from this data.

COMPLAINT INFORMATION

Time Received:

Morning	0230	0435	0800	0841	0900	0940	1000	1046	1100
	1122	1142							
Evening	1233	1328	1400	1610	1630	1730	1748	1830	1943
	2205	2257	2345	Unk					

Time Frames:

12:01 A.M. to 06:00 A.M.	2
06:01 A.M. to 12:00 P.M.	9
12:01 P.M. to 06:00 P.M.	7
06:01 P.M. to 12:00 A.M.	5
Unknown	1

Day of Week:

Monday	2
Tuesday	4
Wednesday	3
Thursday	3
Friday	5
Saturday	4
Sunday	3
Unknown	0

Complainant:

Decedent	2
Perpetrator	8
Family member of the decedent	5
Family member of the perpetrator	0
Neighbor	4
Co-worker	3
Acquaintance of decedent	0
Acquaintance of perpetrator	0
School Teacher	0
Medical Professional	0
Other	4
Unknown	0

Note: *There were a total of 26 calls; this was due to multiple complainants recorded in two reviews.*
Other*: 1 maintenance man, 1 witness at a hotel, 1 new intimate partner and 1 deputy sheriff.*

COMPLAINT INFORMATION – *continued*

Call Received in Relation to Event:

During fatality	6
After fatality	18

911 Tape Available:

Yes	7
No	11
No information	0

Complainant Fear:

High	3
Medium	0
Low	3
Unknown	11

Complainant Threat:

High	2
Medium	0
Low	4
Unknown	11

Dispatch Addressed:

Safety	2
Lang. barrier	0
Other	2
Unknown	13

During Call Complainant Mentioned:

Weapon	8
Death/Murder	13
Children	0
Injunction	0
Alcohol	0
Drugs	0
Unknown	8

EVENT INFORMATION

Offense Type:

Homicide	17
Homicide/Suicide	3
Multiple Homicides	1
Multiple Homicides/Suicide	3
Hostage/Homicide	0
Hostage/Homicide/Suicide	0
Hostage/Multiple Homicides	0
Hostage/Multiple Homicides/Suicide	0

EVENT INFORMATION – *continued*

Event Type:

Intimate Partner	14
Familicide	2
Parricide	1
Killing the Competition	0
Killing of Children by Parent(s)	2
Suicide Pact	0
Mercy Killing	0
Fratricide and/or Sororicide	0
Perpetrator Kills Batterer	0
Ex-intimate Partner	6
Other	1

Other: *Room mate (possible girlfriend of decedent)*
Killing of Children by Parent(s): *includes one unborn child*

Injury that caused death of decedent:

Gun Shot Wound	15	Neglect	0
Stabbing	8	Hanging	0
Strangulation	4	Burn	0
Blunt Trauma	1	Other	1

Other: *Unborn child died as result of fatal gunshot wound to decedent*
Note: *Some fatality review reports contained multiple decedents.*

Death Certified By:

Medical Examiner	28
Medical Doctor	0
Other	1

Law Enforcement Arrived:

Before Fatality	1
During Fatality	1
After Fatality	22

Location Type:

Residence of decedent and perpetrator	17
Residence of decedent	7
Workplace of decedent	2
Other	3

Other*: 1- Hotel, 1- Wooded area, 1-Street.*

Decedent's Activity Prior to Fatality:

In transit to work	0
At work	2
In transit to home	1
Leisure activity	4
School activity	0
Child care activity	0
Household Activity	10
Asleep	4
Other	8

Other: *Smoking crack, getting ready for work, eating, arrived home, In front of home, dressing for work, unborn child, unknown.*

EVENT INFORMATION – *continued*

Other Present at Scene of Fatality:

None	13
Other family/adult	3
Other family/child	4
Friend	0
Acquaintance	1
Stranger/bystander	1
New intimate partner	3
Co-worker	2
Help professional/advocate	0
Law Enforcement	0
Other	2

Other: *Roommate (possible girlfriend of decedent) and neighbor*

Children at Scene of Fatality:

Children present	4
Children not present	19
Not applicable	1

Not applicable: *child is decedent*

Children heard fatal occurrence	2
Children observed fatal occurrence	1

Weapon Type:

Handgun	9
Rifle	3
Shotgun	3
Knife/cutting instrument	8
Hands/fists/feet	5
Other	1

Other: *Unborn child died as result of fatal gunshot would to decedent (mother)*

Injuries sustained during fatality: (decedent)

Blunt trauma	4
Stab/puncture	8
Gunshot	16
Strangulation	4
Poison	0
Burns	3
Other	0

Note: *Some decedents received multiple injuries*

Injuries sustained during fatality: (perpetrator)

Blunt trauma	0
Stab/puncture	3
Gunshot	7
Strangulation	0
Poison	0
Burns	0
Other	4

Other: *Drowning, smoke inhalation, 2 scratches*

EVENT INFORMATION - *continued*

Perpetrator injured by:

Decedent	2
Law Enforcement	1
Decedent family member	0
Witness	0
Self	10
Not Injured	11
Other	0
Unknown	0

Officer/Perpetrator Interaction/Law Enforcement:

Used force	1
Used deadly force	0
Made arrest at scene	8
Identified Suspect at scene	12
No Interaction	5

Time lapse between fatality and suspect arrest:

Perpetrator at large	0
Hours	11
Days	5
Weeks	0
Months	2
Suicide/Death of Perp	6

Status of Perpetrator:

Arrested	4
At-large	0
Killed by Law Enforcement Officer during arrest	0
Committed Suicide During the Fatality	4
Committed Suicide After the Fatality as a separate incident	1
Currently Incarcerated for Fatality	13
Other	2

Other: *1 attempted suicide day of fatality and died two weeks later; 1 found not guilty.*

Custody of Children

Physical:

Not applicable	19
Decedent	2
Perpetrator	0
Both	2
Other	0
Unknown	0

Custody of Children - *continued*

Legal:

Not applicable	0
Decedent	2
Perpetrator	0
Both	1
Other	0
Unknown	1

Sole Parental Responsibility:

Decedent	2
Perpetrator	0
Other family	0
Other	0
Unknown	0

Shared Parental Responsibility:

Decedent	1
Perpetrator	1
Other family	0
Other	0
Unknown	0

Unsupervised Visitation:

Decedent	1
Perpetrator	0
Other family	0
Other	0
Unknown	0

Supervised Visitation:

Decedent	0
Perpetrator	0
Other family	0
Other	0
Unknown	0

Overnight Visits:

Decedent	1
Perpetrator	0
Other family	0
Other	0
Unknown	0

No Visitation:

Decedent	0
Perpetrator	0
Other family	0
Other	0
Unknown	0

Custody of Children - *continued*

Restraining Order for Child

Decedent	0
Perpetrator	0
Other family	0
Other	0
Unknown	0

ENVIRONMENT PRIOR TO FATALITY

Injunction History of Perpetrator:

Active Injunction	2
Previous Injunction	7
Not Applicable	15
Unknown	0

Previous Injunction on Perpetrator by:

Not applicable	2
By decedent	4
Other	3
Unknown	0

Other Injunction Information:

Injunction served on perpetrator	6
Previous injunction violated by perpetrator	0
Current injunction violated by perpetrator	1
Effort by decedent to remove injunction	3
Unknown	2

Conditions of Injunction:

Standard	8
Special Conditions	0
Unknown	1

Perpetrator returned to previous relationship

Yes	0
No	5
Unknown	4

Injunction History of Decedent:

Active Injunction	0
Previous Injunction	3
Not applicable	24
Unknown	0

Previous Injunction on Decedent:

Not applicable	0
By Perpetrator	1
Other	2
Unknown	0

ENVIRONMENT PRIOR TO FATALITY - continued

Other Injunction Information:

Injunction served on decedent	1
Previous injunction violated by decedent	1
Current injunction violated by decedent	0
Effort by perpetrator to remove injunction	0
Unknown	2

Conditions of Injunction:

Standard Condition	2
Specific Condition	0
Unknown	1

Decedent returned to previous relationship with active injunction:

Yes	0
No	1
Unknown	2

DECEDENT INFORMATION

Sex:

Male	4
Female	24
Unknown	1

Marital Status:

Not Applicable *(decedent is a child)*	2
Never Married	8
Widowed	1
Married to perpetrator	7
Married to other	3
Separated from perpetrator	4
Separated from other	0
Divorced from perpetrator	0
Divorced from other	3
Unknown	1

Not Applicable (decedent is a child): *Includes one unborn child*

Race:

Black	11
White	17
Other	1

Other*: Dominican Republic*

DECEDENT INFORMATION - *continued*

Ethnicity:

Hispanic	1
Non-Hispanic	18
Unknown	10

Religion:

Specify	4
None	0
Unknown	24

One victim was a roommate (possible girlfriend of decedent)
Specify: *Four Catholics*

Education of Decedent:

Elementary	1
High School/GED	8
Some college	1
Completed college	1
Graduate School	0
Vocational/Job Training	2
Other	0
Unknown	15
Not Applicable *(decedent is a child)*	1

Not Applicable (decedent is a child): *Includes one unborn child*

Occupation skill level of decedent:

Professional	3
Clerical	1
Laborer	4
Technical	2
Skilled Worker	1
Homemaker	2
Other	4
Unknown	10
Not Applicable *(decedent is a child)*	2

Other: *One teacher, two waitresses and one unknown*
Not Applicable (decedent is a child): *Includes one unborn child*

Employment Status:

Employed	11
Unemployed	4
Retired	3
Unknown	9
Not Applicable *(decedent is a child)*	2

Not Applicable (decedent is a child): *Includes one unborn child*

DECEDENT INFORMATION - *continued*

Other Source(s) of Income of Decedent:

No other source	6
Government assistance	2
Current partner support	1
Spousal support	2
Solely dependent on perpetrator	0
Other	2
Unknown	12
Not Applicable *(decedent is a child)*	2

Other: *One temporary work, and one provided no information*

Criminal History:

Non Violent Crime Arrests	16
Domestic Violent Arrests	3
Other Violent Arrests	3

Other Related History:

Documented police response to residence	11
Decedent victim of other offenses	6
Previous incidents of domestic violence with different partner(s)	5
History of domestic violence known to other(s)	15

PERPETRATOR INFORMATION

Sex:

Male	22
Female	2

Martial Status:

Never Married	11
Widowed	0
Married to decedent	7
Married to other	2
Separated from decedent	4
Separated from other	0
Divorced from decedent	0
Divorced from other	0
Not Applicable *(decedent is a child)*	0

PERPETRATOR INFORMATION - *continued*

Race:

Black	11
White	12
Asian/Pacific Islander	1
Unknown	0

Ethnicity:

Hispanic	1
Non-Hispanic	15
Unknown	8

Religion:

Specify	3
None	0
Unknown	21

***Specify**: One Catholic, one Baptist and one Wicka (Cult)*

Education of Perpetrator:

Elementary	1
High School/GED	4
Some college	3
Completed college	1
Graduate School	0
Vocational/Job Training	1
Other	1
Unknown	13

Occupation skill level of perpetrator:

Professional	1
Clerical	0
Laborer	11
Technical	1
Skilled Worker	1
Homemaker	1
Other	7
Unknown	2

Employment Status:

Employed	13
Unemployed	7
Retired	1
Unknown	3
Not Applicable *(decedent is a child)*	0

PERPETRATOR INFORMATION - *continued*

Other Source(s) of Income of Perpetrator:

No other source	6
Government assistance	1
Current partner support	1
Spousal support	1
Solely dependent on decedent	2
Other	2
Unknown	12

Criminal History:

Non Violent Crime Arrests	16
Domestic Violent Arrests	13
Other Violent Arrests	12
Unknown	0

Other Related History:

Previous incident of domestic violence with different partners	7
Previous history of suicide attempt	4
Known allegations of stalking	6
Previous participation in batterer's intervention program	3
Previous abuse of drugs	9
Previous use of alcohol	12
Under medication	3
Previous incident(s) of animal abuse	0
Appeared in court for domestic violence offense	12
Domestic violence related charges dismissed against perpetrator	7
Perpetrator suspect/charged in death of former intimate partner	1
Perpetrator former intimate partner died in accident/mysterious	1
History of domestic violence known to other entities	19
Known incidents of prior child abuse	4

PERPETRATOR SUICIDE

Cause of Death:

Gunshot wound	3
Stabbing	1
Drowning	1
Smoke inhalation	1

Suicide Note Left	***0***
Suicide appear part of homicide	***4***
Suicide separate and distinct incident from fatality	***2***

RELATIONSHIP ISSUES

Relationship of Decedent to Perpetrator:

Spouse	10	In-Laws	1
Parent	3	Co-habitant	7
Girlfriend	0	Ex-cohabitant	4
Child	2	Other known	1
Boyfriend	0	Ex-girlfriend	1
Ex-spouse	0		

***Other know**n: One roommate (possible girlfriend of decedent)*
***Child**: Consists of one unborn child*

Reported Prior Threats Made to Decedent by Perpetrator:

Threat to kill decedent	11
Threat to kill children or family member	2
Threat to commit suicide	8
Other	4

***Other:** One threat to new boyfriend, one threat to kill decedent's new intimate partner, one threat to disfigure decedent and one threat to take children*

Circumstance That Apply to Decedent and Perpetrator's Relationship:

They lived together at some point	26
They lived together at the time of the fatality	18
They were intimate prior to the fatal incident	6
They had a child/children in common	7
They had children in household, but not in common	6
Always maintained separate dwellings	1
They had previous report incidents of domestic violence	13
They had a significant change in relationship	17

CONTRIBUTING FACTORS TO INCIDENT

Priority Rating: (with 1 being the highest and 3 the lowest)

Relationship Factors:	**Priority 1**	**2**	**3**
Signs of recent sexual intercourse with decedent by other	3	0	0
Decedent and perpetrator in process of separation at time of fatality	4	4	0
Decedent and perpetrator had separated	1	3	1
Decedent had started a new relationship	2	3	1
Perpetrator had started a new relationship	1	0	1

Employment/Monetary Factors:	**Priority 1**	**2**	**3**
Perpetrator had loss of income recently	0	2	1
Perpetrator had loss of income recently blames decedent	0	1	0

CONTRIBUTING FACTORS TO INCIDENT - *continued*

Criminal Justice Interaction Factors:	**Priority 1**	**2**	**3**
Perpetrator had been served with an injunction	0	0	1
Perpetrator was arrested for domestic violence on decedent	0	1	1
Perpetrator was arrested for domestic violence on another partner	0	0	1

Substance Abuse Factors:	**Priority 1**	**2**	**3**
Perpetrator has/had abused drugs	4	0	0
Decedent had/has abused drugs	0	0	1
Perpetrator had/has abused alcohol	1	3	3
Decedent had/has abused alcohol	1	2	1

Health/Mental Health Factors:	**Priority 1**	**2**	**3**
Perpetrator taking a non prescription medication at time of fatality	0	0	0
Decedent taking a non prescription medication at time of fatality	0	0	0
Medication prescribed for perpetrator at time of fatality	0	0	0
Medication prescribed for decedent at time of fatality	0	0	0
Perpetrator taking prescribed medication at time of fatality	0	0	0
Decedent taking prescribed medication at time of fatality	0	0	0
Perpetrator taking psychiatric medication at time of fatality	0	0	0
Decedent taking psychiatric medication at time of fatality	0	0	0
Perpetrator had/has mental health problems	2	1	1
Decedent had/has mental health problems	0	1	0
Perpetrator attempted to commit suicide prior to fatality	0	0	0
Decedent attempted to commit suicide prior to fatality	0	0	0

Other Factors:	**Priority 1**	**2**	**3**
Perpetrator alleged to have committed act to avenge a perceived wrongdoing:			
By decedent	3	2	2
By decedent family member	0	0	1
By other	0	1	0
Immigration status in question pertaining to decedent	0	0	0
Immigration status in question pertaining to perpetrator	0	0	0

Other (specify):	**Priority 1**	**2**	**3**
Dispersement of money during separation	1	0	0
Mother-in-law (Grandma) complained about kids	0	0	1
Upset with decedent	1	0	0
Upset over No Contact Order	1	0	0

ESCALATING CIRCUMSTANCES

The Decedent:

Expressed fear of physical danger to themselves or children	11
Express fear of losing custody of children	2
Isolate themselves from family and friends	1
Had evidence of physical injury	8
Showed frequent signs of	
Depression	3
Anger	4
Low self-esteem	3
Suicidal thoughts	2
Expressed fear of involvement in the criminal justice system process	1
Showed or expressed signs of sleeping difficulties	1
Expressed guilty feelings about the failed relationship	1
Showed or expressed history of family abuse	0
Expressed fear of being alone	1
Expressed fear of making a great life change	2
Expressed belief that partner would change their behavior	2

The Perpetrator:

Abuse the decedent in public	6
Kept tabs on or stalk decedent	6
Put down the decedent's friends and family	2
Tell decedent, jealousy is a sign of love	1
Make all decisions in the relationship (including finances)	2
Blame decedent for abuse	4
Use intimidation	7
Smash objects, destroy property	5
Tell the decedent their fears about relationship not important	1

SERVICES REQUESTED, ORDERED OR OBTAINED

Domestic Violence Services:

Domestic Violence counseling services	**Requested**	**Received**
Decedent	1	0
Perpetrator	1	2

Domestic Violence center	**Requested**	**Received**
Decedent	0	0
Perpetrator	0	0

Religious	**Requested**	**Received**
Decedent	0	0
Perpetrator	0	0

Children Services	**Requested**	**Received**
Decedent	2	2
Perpetrator	0	0

SERVICES REQUESTED, ORDERED OR OBTAINED - *continued*

Supervised visitation center

	Requested	Received
Decedent	1	1
Perpetrator	0	0

Other

	Requested	Received
Decedent	0	0
Perpetrator	1	0

Total Domestic Violence Services:
Decedent: **Requested: 4 Received: 3**
Perpetrator: **Requested: 2 Received: 2**

Criminal Justice/Legal Assistance:

Law Enforcement:

	Requested	Received
Decedent	9	11
Perpetrator	5	12

Legal Assistance/attorney

	Requested	Received
Decedent	3	5
Perpetrator	3	6

State Attorney/Prosecutor

	Requested	Received
Decedent	1	4
Perpetrator	1	9

Court/Judges

	Requested	Received
Decedent	4	6
Perpetrator	2	8

Family Court

	Requested	Received
Decedent	4	4
Perpetrator	2	6

Probation/Parole

	Requested	Received
Decedent	1	3
Perpetrator	2	4

Other (specify)

	Requested	Received
Decedent	1	0
Perpetrator	0	0

Total Criminal Justice/Legal Assistance
Decedent: **Requested: 23 Received: 33**
Perpetrator: **Requested: 15 Received: 45**

Health Care Provider:

EMT/Paramedics

	Requested	Received
Decedent	1	6
Perpetrator	0	3

SERVICES REQUESTED, ORDERED OR OBTAINED - *continued*
(Health Care Provider)

Ambulance service

	Requested	Received
Decedent	0	3
Perpetrator	1	3

Emergency room

	Requested	Received
Decedent	1	3
Perpetrator	0	2

Physician

	Requested	Received
Decedent	1	2
Perpetrator	0	1

Mental Health Clinic

	Requested	Received
Decedent	0	0
Perpetrator	1	1

Mental Health program

	Requested	Received
Decedent	0	0
Perpetrator	1	1

Other:

	Requested	Received
Decedent	1	2
Perpetrator	0	1

Total Health Care Provider:
Decedent: **Requested: 4 Received: 16**
Perpetrator: **Requested: 3 Received: 12**

Children Services:

DCF

	Requested	Received
Decedent	2	4
Perpetrator	2	4
Child of decedent	4	6
Child of perpetrator	3	5

School Involvement

	Requested	Received
Decedent	0	0
Perpetrator	0	0
Child of decedent	0	1
Child of perpetrator	0	2

Other (children services)

	Requested	Received
Decedent	0	1
Perpetrator	0	1
Child of decedent	1	1
Child of perpetrator	1	1

Decedent: **Requested: 2 Received: 5**
Perpetrator: **Requested: 2 Received: 5**
Child of Decedent: **Requested: 5 Received: 8**
Child of Perpetrator: **Requested: 4 Received: 8**

LETHALITY INDICATORS

Emotional/Mental Deterioration:	Decedent	Perpetrator
Suicidal	2	12
Homicidal	0	14
Loss of function (i.e. not eating, sleeping, working)	0	4
History of psychiatric problems	0	3
Poor compliance with taking medication	0	1
Depression	3	5
Economic loss	3	5
Loss of family support	3	2
No Information provided	21	5

Antisocial Behavior:	Decedent	Perpetrator
History of domestic violence	3	17
History of assaults on other	2	10
History of criminal activity	6	15
History of stalking	0	6
History of substance abuse	8	13
Possession of weapons	3	10
History of abusing children (physically or sexually)	2	4
History of childhood abuse or witnessing violence	0	1
No information provided	17	3

Failure of Community Control:	Decedent	Perpetrator
Violation(s) of restraining order	1	2
Violation(s) of probation	3	4
Arrest(s) for domestic violence	2	9
Fail complete Batterer's Intervention Program	0	4
Failure to complete Substance Abuse Treatment	1	1
Failure to complete Anger Management Program	0	1
No information provided	22	13

Severity of Violence:	Decedent	Perpetrator
Used a weapon	2	9
Death threat	1	8
Unwanted sexual contact	0	2
Strangulation	0	2
Hurt pet	0	0
Severe injury	1	1
Sadistic/Threatening act	0	3
Expressed concerns that she/he would be killed	8	0
No information provided	18	11

Ownership/Centrality of Victim to Perpetrator:	Decedent	Perpetrator
Obsessive about partner or family	0	11
Extreme jealousy	0	12
Access to victim and/or family members	1	11
Rage and/or depression over separation	0	9
Perceived betrayal	1	12
Perceived rejection after attempt to reconcile	0	9
No information provided	25	8

SUMMARY OF REPORTS

Prior to the fatality, were there any indications that the level of abuse was increasing?

Yes	12
No	8
Unknown	4
No information provided	0

Entities that had knowledge of the domestic violence:

Law Enforcement	11
Family	15
Acquaintances/Neighbors	8
Friends	11
State/County Agencies	7
Employers/Co-workers	7
Military	0
Abuse Centers/Shelters	1
No information provided	0
No known entities had knowledge of abuse	7
Medical	0