



# FACES OF FATALITY

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

**Volume VIII • June 2018**

*Every domestic violence homicide is a tragedy that underscores the necessity of domestic violence fatality review teams. The work of the teams honors the lives of those killed by seeking ways to prevent additional murders at the hands of domestic violence perpetrators. Gaining insight into these deaths is critical to the safety of Floridians. I am proud to partner with the Florida Coalition Against Domestic Violence in co-chairing the Statewide Domestic Violence Fatality Review team and recognize the exemplary law enforcement officers, prosecutors, and team members whose efforts contribute to the reduction of domestic violence homicide in Florida.*

—Attorney General Pam Bondi

*The senseless loss of life caused by domestic violence homicide is a tremendous concern for Florida. Those who were tragically killed last year left many communities to grieve for their mothers, daughters, sisters, and friends or loved ones. The Statewide Domestic Violence Fatality Review Team and the 25 local teams create a critical collaboration that seeks to reduce and ultimately prevent domestic violence fatalities in our State. The Florida Coalition Against Domestic Violence, in partnership with the Office of the Attorney General, remains committed to the work of the statewide team in implementing potential solutions that increase the safety of survivors and their children while holding perpetrators accountable for their violence. We are grateful for the ongoing commitment of community partners who tirelessly work toward safety and justice for domestic violence survivors and their children.*

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

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

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# EXECUTIVE SUMMARY

Domestic violence homicides continue to occur at alarming numbers. The Annual Uniform Crime Report (UCR)<sup>1</sup> statistics released in May 2018 by the Florida Department of Law Enforcement (FDLE) reflected a 9.5% decrease in domestic violence murders in 2017 from the previous year. However, domestic violence manslaughter deaths increased by 28.6% during the same time period. This alarming increase of domestic violence manslaughter cases requires immediate action to prevent such deaths from occurring in Florida. There were a total of 180 domestic violence-related homicides in Florida in 2017.<sup>2</sup>

The Florida Attorney General's Statewide Domestic Violence Fatality Review Team was formed in 2009 in response to a statewide increase in domestic violence homicides. The team convenes semi-annually to analyze data collected by local teams from fatality reviews; to conduct a comprehensive review of selected domestic violence homicides including identification of events leading up to the fatalities; and to close gaps in the delivery of services and response to survivors, their children, and perpetrators. The team creates recommendations designed to enhance protective measures for survivors and their children, and accountability measures for perpetrators of the violence. Recommendations assist community domestic violence response efforts to educate the general public and strengthen, as well as transform the work of system partners. The goal of the team is to augment systemic responses and services that support the prevention of these tragic fatalities from occurring in our state. The statewide team is co-chaired by the Florida Attorney General's Office and the Florida Coalition Against Domestic Violence (FCADV). Members of the team represent state and local entities that interact with survivors, their children, and perpetrators, including representatives from the court system, law enforcement, probation, parole, faith-based organizations, educators, certified domestic

violence centers, legal providers, and healthcare professionals.

Florida's statewide team and the 25 local teams review domestic violence fatalities and near fatalities that occur in diverse communities across Florida. The teams utilize a "no blame, no shame" philosophy that concentrates on solution focused community collaborations to prevent domestic violence homicides. All teams comply with statutory mandates to maintain confidentiality and public records exemptions when reviewing fatality related information.<sup>3</sup> The statute requires teams to exempt from disclosure the identities of victims and their children. Additionally, all information and records obtained by domestic violence fatality review teams are not subject to discovery or introduction into evidence, and persons attending the meetings may not testify in any civil or criminal action or administrative or disciplinary proceeding if the information or records arose out of matters that are the subject of evaluation and review by the domestic violence fatality review team. These statutory mandates ensure that team members may freely discuss the circumstances and issues relating to the fatalities.

The 2018 Faces of Fatality VIII report includes the statewide team's review of a 2016 homicide/suicide, and data analysis of reviews completed by all 25 of Florida's local domestic violence fatality review teams from January through December 2017. The inclusion of the local teams' data provides a demographic profile and an outline of the experiences of the decedents and perpetrators leading up to each tragic death. The reviews reflect that 90% of the perpetrators were male and 84% of decedents (victims) were female. Disparities between perpetrators and decedents in occupational status and the years of formal education emerged in the data analysis. On average, similar to the previous year, decedents were more likely to have completed high school/college and less



likely than perpetrators to be unemployed. The victim in the case reviewed by the statewide team maintained full-time employment while the perpetrator was unemployed.

The data reported by local teams highlights high-risk indicators that were also identified in research conducted related to intimate partner homicides. Teams also contribute unique findings and notable factors in their reviews to strengthen the understanding of domestic violence homicide(s) in Florida. The perpetrator's prior history of domestic violence, history of stalking, prior use of weapons and history of substance abuse were the most commonly reported high-risk indicators identified by local teams in this year's report. Nearly 50% of those committing the homicides possessed a known history of stalking and domestic violence perpetration. More than 60% of perpetrators were known to have a history of substance abuse and carry or possess a weapon. Thirty-three percent (33%) of perpetrators were using substances during the time of the homicide.

A total of 80% of decedents had children and 71% of those children had a biological parent other than the perpetrator. In 28% of the domestic violence fatalities, there were known child witnesses. Forty-four percent (44%) of decedents or their family members had contact with the Department of Children and Families (DCF) prior to the homicide. Of the homicides reviewed, 67% occurred in a residence shared by the perpetrator and

decedent. Fifty-five percent (55%) of family members reported knowing about prior incidents or threats of domestic violence made by the perpetrator.<sup>4</sup> There were known allegations of death threats made by the perpetrator toward the decedent prior to the homicide in 35% of the reviewed fatalities and the perpetrator used a firearm in 66% of the cases.

The critical need for community and system partners to proactively respond to domestic violence through a coordinated community response is highlighted by the parallel findings of the local fatality review teams and the risk indicators identified through research. The effectiveness of interventions to support the safety of survivors and their children increases when community partners collaboratively work together to develop strategies and policies to hold perpetrators accountable for their violence.<sup>5</sup> Fatality review creates a platform for local and state entities that have contact with survivors, their children, and perpetrators to address systemic gaps and recommend interventions and policies that enhance domestic violence services and reduce the likelihood of future homicides. This report provides information for legislators, state agencies, social service organizations, certified domestic violence centers and community members to strengthen their efforts to prevent domestic violence-related homicides and increase their communities' knowledge regarding the devastating impact of domestic violence on survivors, their children and other family members.

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<sup>1</sup><http://www.fdle.state.fl.us/FSAC/UCR/2017/CIFAnnual17.aspx>

<sup>2</sup>ibid.

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

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

<sup>5</sup>Duluth: A Coordinated Community Response to Domestic Violence (From The Multi-Agency Approach to Domestic Violence: New Opportunities, Old Challenges?, P 150-168, 1999, Nicola Harwin, Gill Hague, et al., eds. -- See NCJ-187541)

# FINDINGS

The 2018 Faces of Fatality report contains descriptive statistics of domestic violence homicides based on data collected by Florida's local fatality review teams between January 2017 and December 2017. The 32 homicides reviewed occurred between 2008 and 2017, with the majority of fatalities occurring from 2013 to 2017.

Aggregated data analysis helps to identify patterns and trends related to domestic violence homicides and emphasizes critical areas of focus related to improving policy and intervention strategies. The data in this report is generated from both qualitative and quantitative sources. The teams gathered information from public records, media reports, and conversations with proxy informants such as law enforcement and family members or friends of the deceased. The information provides a contextual view of the perpetrators' behaviors and the victims' experiences prior to and leading up to the homicides. The local teams utilize a uniform data collection tool to gather and report information regarding the characteristics of perpetrators and decedents relationships with perpetrators, known domestic violence histories, criminal records, and observable risk factors, including but not limited to stalking, strangulation, abuse while the victim was pregnant, obsessive jealousy and a range of other violent behaviors.

This report also presents a case study and findings based on the fatality review of a murder/suicide conducted by the statewide team. The perpetrator murdered a woman with whom he had been living. Her two young children were present in the home during the time of the homicide. He fatally shot himself shortly after killing the decedent. This horrific fatality and the effects of such a deep loss and trauma on surviving loved ones reveals the critical need for changes in systemic and community-based responses to the crime of domestic violence. The Faces of Fatality Annual Report seeks to honor the victim's memory by developing recommendations intended to create safe outcomes for survivors and their children and prevent future homicides in Florida.

## **Findings from the 2017-2018 local fatality reviews highlight several themes regarding victim and perpetrator profiles, as well as factors that indicate a heightened risk of lethality:**

- 39% of perpetrators were unemployed at the time of the homicide.
- 62% of perpetrators were reported to have substance abuse histories.
- 30% of perpetrators were reported to have a professionally diagnosed mental health disorder.
- In 48% of the fatalities, there was known prior stalking behavior on the part of the perpetrator.<sup>6</sup>
- 68% of perpetrators were known by family or friends to carry or possess a weapon.

- 43% of decedents and perpetrators were separated at the time of the homicide and the average length of separation when known, was approximately 5.5 years.
- 35% of fatalities had known prior death threats made by the perpetrator towards the decedent, based on victim reporting.
- 42% of perpetrators had a known non-domestic violence-related criminal history.
- 48% of perpetrators had a known criminal history of domestic violence and in 52% of fatalities, there were known prior reports to the police by the decedent alleging domestic violence by the perpetrator.
- 55% of perpetrators had a known criminal history of any kind, domestic violence-related or otherwise, based on criminal records and narrative reports.
- In 55% of the fatalities, family members reported knowing about prior incidents or prior threats of domestic violence on the part of the perpetrator.
- In 32% of the fatalities, there was a known criminal order of no contact issued against the perpetrator.
- In 32% of the fatalities there was a known permanent civil injunction for protection filed against the perpetrator by the decedent.
- In 19% there was a known permanent civil injunction for protection filed against the perpetrator by someone other than the decedent.
- 48% of perpetrators died by suicide and an additional 14% attempted but did not complete suicide.

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

There were several indicators of increased risk for lethality including:

- The perpetrator possessed access to firearms and had used them to threaten the victim.
- The perpetrator had previously attempted to strangle the victim.
- The perpetrator was unemployed.
- The perpetrator had a prior criminal history of domestic violence, including battery on a pregnant person.
- The perpetrator was living in a home with children that had a biological parent other than the perpetrator.

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<sup>6</sup>See s. 784.048, F.S.

# RECOMMENDATIONS

**FCADV should develop and distribute informational materials, such as new Public Service Announcements (PSAs) that educate family members and friends of survivors of domestic violence regarding the warning signs and dynamics of domestic violence, and services available through certified domestic violence centers and the Florida Domestic Violence Hotline. The PSAs will contribute to FCADV's "It Starts with Me" video series created to inform workplace professionals about the role of bystanders in ending domestic violence. The videos will be utilized during Domestic Violence Awareness Month and throughout the year to promote domestic violence services and encourage friends and family to respond to domestic violence in a safe and supportive manner.**

Faces of Fatality reports from 2014-2018 indicated that over 50% of family members in the homicides reviewed reported knowing about prior incidents or prior threats of domestic violence on the part of the perpetrator. Encouraging supportive intervention from bystanders, such as family members and friends, is an important strategy that may reduce the prevalence of domestic violence.<sup>7</sup> Fear for their personal safety may prevent bystanders from intervening when witnessing the perpetrator's violence. While bystanders may be aware of the abuse, they frequently do not know what to say for fear of offending or alienating the survivor. Bystanders may also believe that "it's not their problem" or that they are interfering, which contributes to their silence.<sup>8</sup> Sixty-five percent (65%) of survivors who disclosed abuse in a national survey reported that they were not helped by their friends.<sup>9</sup> The stigma associated with intimate partner violence may inadvertently contribute to victim-blaming attitudes that inhibit bystanders from offering crucial support to survivors.

Producing PSAs about the importance of recognizing domestic violence, holding perpetrators accountable for their violence, and providing support services to survivors can diminish the stigma of domestic violence and aid in the safety of victims. Bystanders need information regarding the dynamics of domestic violence and knowledge of appropriate resources to respond supportively to their family, friends and loved ones. The PSAs should include information related to resources for survivors, warning signs of abuse and conversation starters for talking with survivors such as "it's not your fault," "you don't deserve this abuse," and "there are people and agencies who can help you."



**FCADV should convene a workgroup with stakeholders including, but not limited to, the Department of Children and Families, Office of Early Learning, and other stakeholders to review current training material related to appropriate domestic violence education for childcare providers and recommend enhancements to online and/or in person trainings.**

Currently, employees of certified childcare centers in Florida are required to complete 40 hours of introductory training.<sup>10</sup> However, the training does not include information related to domestic violence. Research indicates that bystanders are more likely to intervene in instances of domestic violence when young children are involved.<sup>11</sup> Additional research underscores that the non-offending parent (survivor of domestic violence) is often the strongest protective factor in the lives of children who are exposed to domestic violence.<sup>12</sup> Therefore, it is important that childcare providers partner with the non-offending parent to ensure the safety of the children. It is critical that childcare providers have knowledge about the dynamics of domestic violence and perpetrator tactics, as well as the resources available to survivors. Such knowledge will help to dispel the stigma and victim-blaming attitudes surrounding domestic violence that are often present in the general population, and increase safety for the survivor and child(ren) in the household. By developing an understanding of the coercive tactics used by perpetrators, childcare providers will be able to offer relevant and often time-sensitive resources and referrals for survivors with whom they come into contact.

Historically, FCADV has partnered with organizations that provide support to pregnant mothers and new parents by developing and implementing comprehensive training materials related to domestic violence. The workgroup should utilize the existing training content as the foundation for developing curricula for childcare providers. Training material should include, at minimum, the dynamics of domestic violence, warning signs of domestic violence, perpetrator tactics, risk indicators for domestic violence homicide, and information related to certified domestic violence centers and other resources for survivors and their children.

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<sup>7</sup>Wee, S.; Todd; MJ; Oshiro, M; Greene, E.; Frye, V. Modifiers of Neighbors' Bystander Intervention in Intimate Partner Violence: A Concept Mapping Study. *Violence and Gender* 2016 Mar 1; 3(1): 55-63

<sup>8</sup><https://nomore.org/bystander-basics/>

<sup>9</sup><https://nomore.org/campaigns/see-the-signs-speak-out/>

<sup>10</sup><http://www.myflfamilies.com/service-programs/child-care/facilities>


<sup>11</sup>Wee, S.; Todd; MJ; Oshiro, M; Greene, E.; Frye, V. Modifiers of Neighbors' Bystander Intervention in Intimate Partner Violence: A Concept Mapping Study. *Violence and Gender* 2016 Mar 1; 3(1): 55-63

<sup>12</sup>Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice. Recommendations from the National Council of Juvenile and Family Court Judges Family Violence Division, 1999.

# RECOMMENDATIONS

**The Florida Coalition Against Domestic Violence, Florida Prosecuting Attorneys Association, Florida Police Chiefs Association, Florida Sheriffs Association and local law enforcement agencies should collaborate to develop and expand focused deterrence initiatives that are directed toward chronic and repeat perpetrators of intimate partner violence. Focused deterrence models identify perpetrators with extensive criminal records and hold them accountable for the violence they commit with swift and predictable consequences.<sup>13</sup> A deterrence model encourages local law enforcement agencies and community partners to treat all perpetrators of chronic and repeat domestic violence, dating violence, sexual violence and stalking as serious violations of the law requiring the coordinated effort of the entire criminal justice system. Perpetrators receive specific notifications from law enforcement based on the level of severity of the offense they commit. The deterrence model should build upon FCADV's Intimate Violence Enhanced Services Team (InVEST) and FCADV's Law Enforcement Enhanced Response Statewide Initiative which fund dedicated law enforcement officers to investigate domestic violence, dating violence, sexual violence and stalking, enhance policies related to domestic violence response, as well as strengthen partnerships with certified domestic violence centers, the State Attorney's offices and other community stakeholders to increase offender accountability while maintaining the safety for survivors and their children.**

The perpetrator of the homicide reviewed by the statewide team possessed an extensive criminal history that included prior domestic violence, drug possession, carrying a concealed firearm, and theft. Focused deterrence initiatives identify different levels of intervention to address chronic perpetrators with multiple criminal charges. The success of focused deterrence initiatives require widespread collaboration among law enforcement, prosecutors, courts and advocates for survivors to ensure that perpetrators are aware that increased surveillance of their behavior is in effect.



This year's reviews identified that 52% of decedents reported incidents of domestic violence committed by the perpetrator to law enforcement compared to 31% in 2017. This increase in reporting highlights the importance of collaboration among community partners to hold perpetrators accountable and enhance safety for survivors and their children. FCADV's InVEST and Law Enforcement Enhanced Response funded agencies currently utilize similar models to increase criminal justice system partners' awareness of high-risk offenders in their area. As a part of these programs, FCADV conducts training on enhancing investigation and prosecution in domestic violence cases. Ongoing training and technical assistance are critical to the success of these initiatives and should be included in new or expanded programs developed by the aforementioned partners.

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<sup>13</sup><http://www.bwjp.org/resource-center/resource-results/north-carolina-offender-focused-deterrence.html>

# FATALITY REVIEW

The statewide team convened three meetings during the 2017-2018 fiscal year. In addition to reviewing data from the local teams and discussing recommendations, the team conducted a review of a 2016 murder/suicide. This review is based on information from public records, including court documents, police reports, media reports, interviews with the law enforcement agency personnel that investigated the homicide/suicide, and a conversation with a family member of the victim.

In September 2016, T.R., age 29, murdered B.D, age 23, in the residence in which they lived together.<sup>14</sup> A neighbor reported hearing a loud verbal altercation followed by a single gunshot during the argument. T.R. called 911 to report that B.D. shot herself, was no longer breathing, and needed medical help. T.R. fatally shot himself while still on the line with the dispatcher before law enforcement was able to respond. The victim planned to take her children to the movies with her family on the day of the homicide. Family members tried to reach her to confirm the plans, but she was killed before the outing. A friend of the perpetrator reported to law enforcement that he visited the perpetrator's home earlier in the day and believed the couple was "having difficulties." During the visit, the perpetrator told his friend that he needed to get out of the house for a while and asked the friend to come back later. When the friend arrived to pick up the perpetrator, law enforcement was on the scene.

The investigation into the deaths concluded that T.R. shot B.D. with a firearm and then shot himself with the same weapon. There were no prior law enforcement responses to the residence for domestic violence. However, the perpetrator had an extensive criminal history that included prior domestic violence, drug possession, carrying a concealed firearm without a permit, and theft. B.D. is remembered as a strong woman and a loving mother, daughter, sister, cousin and friend who is greatly missed due to this devastating murder.

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<sup>14</sup>Out of respect for the involved and affected parties, the initials of the victim and perpetrator have been changed.



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

- B.D. shared with friends and family members incidences of the perpetrator's prior violence toward her including an attempted strangulation that occurred a few months before the fatality. He was reported to have threatened her with a firearm during this incident.
- B.D., her two children, and T.R. lived together at the residence where the murder occurred for approximately six months. At the time of the homicide, T.R.'s son from a previous relationship had recently joined the household on a permanent basis.
- Family members and friends of the victim witnessed T.R. engaging in controlling behaviors toward B.D. They reported that he argued with the victim and verbally intimidated her. They reported seeing a gun in plain view in the living room on at least one occasion.
- T.R. had two separate charges for incidents of battery toward another partner prior to his relationship with the decedent. In the first incident, law enforcement was called after a family member overheard a conversation in which the victim stated that T.R. had punched her in the face during a dispute. The officer on the scene noticed swelling on the victim's face and arrested T.R. for simple battery. The victim stated that her injuries were the result of accidentally hitting her face on a door. The case was closed within three weeks of the arrest. T.R. was also charged with battery on a pregnant person (the same victim as in the former arrest) three years later. Law enforcement was called after a witness observed T.R. holding the victim against the wall. The officer arriving on the scene observed T.R. pinning the victim against the wall, yelling in her face and not allowing her to move. T.R. was arrested for simple battery, however, the case was not prosecuted.
- T.R. had numerous other prior criminal charges including battery, grand theft, carrying a concealed firearm, possession of cocaine, possession of cannabis in excess of 20 grams, obstructing an officer without violence and driving with a suspended license.

# LOCAL FATALITY REVIEW TEAM DATA ANALYSIS

The descriptive statistics in the 2018 report are based on information that local teams obtained from reviewing domestic violence homicides in their communities. The reviews may include both intimate partner homicides and other domestic violence-related deaths. When possible, the data points are based on information collected from all 32 reviews submitted by local teams. **In some instances, however, statistics are based on different totals.** This is either due to non-applicability or missing information for any given review. Therefore, the totals may not always equal the total sum of 100. The total number of cases used to calculate each statistic is provided in parentheses. In one out of the 32 cases reviewed this year, the reviewers identified the perpetrator of the homicide as acting in self-defense to domestic violence. This review was excluded in the descriptive statistics that inquire about specific details of perpetrators or decedents because of the unique circumstances surrounding that homicide. The evidence-based research related to known risk factors is based on cases of intimate partner femicide, which are male perpetrated homicides on their female partners. Therefore, information on the breakdown of known risk factors contains data related to the 26 deaths resulting from intimate partner femicide.

YEAR OF INCIDENT	# OF REVIEWS
2008	1
2009	1
2010	1
2011	2
2012	1
2013	5
2014	6
2015	4
2016	9
2017	1
Unknown	1
<b>Total</b>	<b>32</b>

## Perpetrator Characteristics

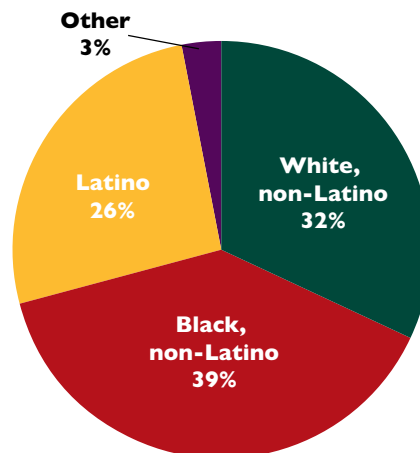
Gender: 90% male (28 of 31), 10% female (3 of 31)

### Race/ethnicity:

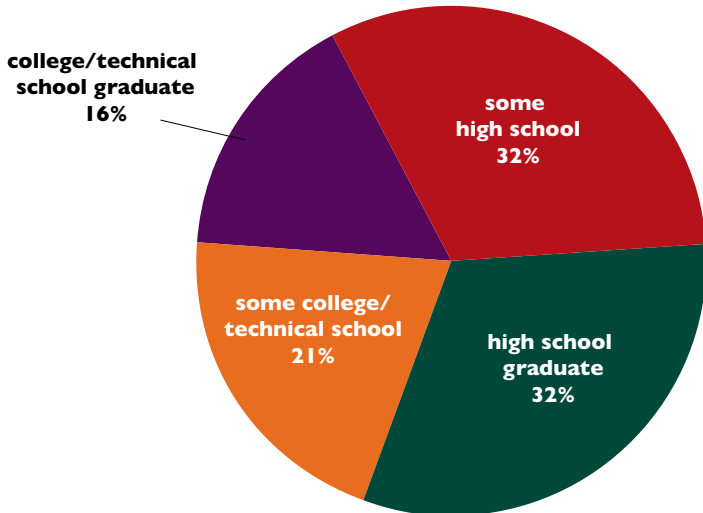
- 39% Black, non-Latino (12 of 31)
- 32% White, non-Latino (10 of 31)
- 26% Latino (8 of 31)
- 3% Other (1 of 31)

**Average age:** 43 (min: 17, max: 93)

## PERPETRATOR RACE/ETHNICITY



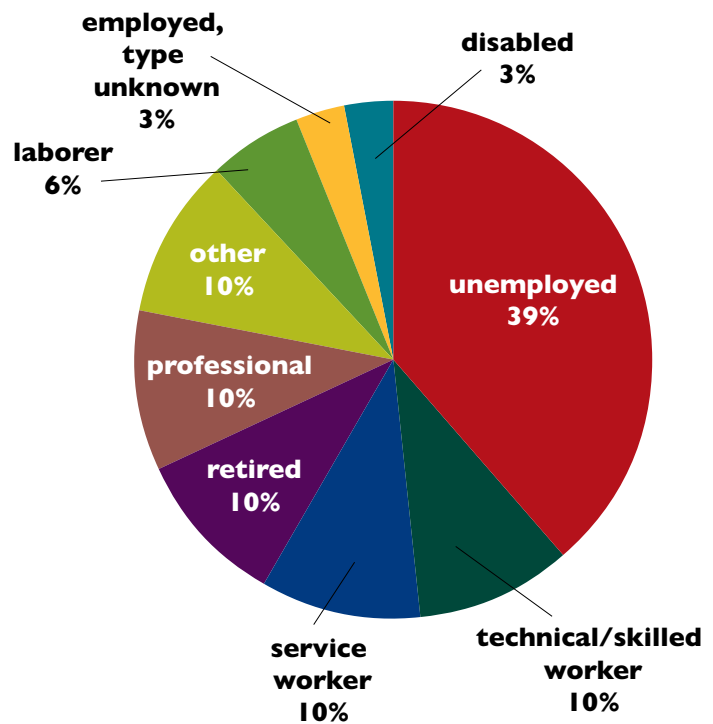
## PERPETRATOR EDUCATION LEVEL



### Education level:<sup>15</sup>

32%	some high school (6 of 19)
32%	high school graduate (6 of 19)
21%	some college/technical school (4 of 19)
16%	college/technical school graduate (3 of 19)

## PERPETRATOR EMPLOYMENT STATUS



### Employment type:

39%	unemployed (12 of 31)
10%	technical/skilled worker (3 of 31)
10%	service worker (3 of 31)
10%	retired (3 of 31)
10%	professional (3 of 31)
10%	other (3 of 31)
6%	laborer (2 of 31)
3%	employed, type unknown (1 of 31)
3%	disabled (1 of 31)

## Other Known Perpetrator Characteristics

- Reviewers reported that 62% of perpetrators (18 of 29) had known substance abuse problems of some kind (based on various sources, e.g., DUI records, police reports, substance abuse services, and/or personal narratives from self, family, friends, or co-workers).
- Reviewers reported diagnosed mental health disorders in 30% (8 of 27) of perpetrators.
- Reviewers reported that 48% (14 of 29) of perpetrators exhibited prior stalking behavior.
- Reviewers reported that 68% (19 of 28) of perpetrators were known by family or friends to carry or possess a weapon.

<sup>15</sup>The teams were able to gather data on 19 perpetrators.

# LOCAL FATALITY REVIEW TEAM DATA ANALYSIS

## Decedent Characteristics

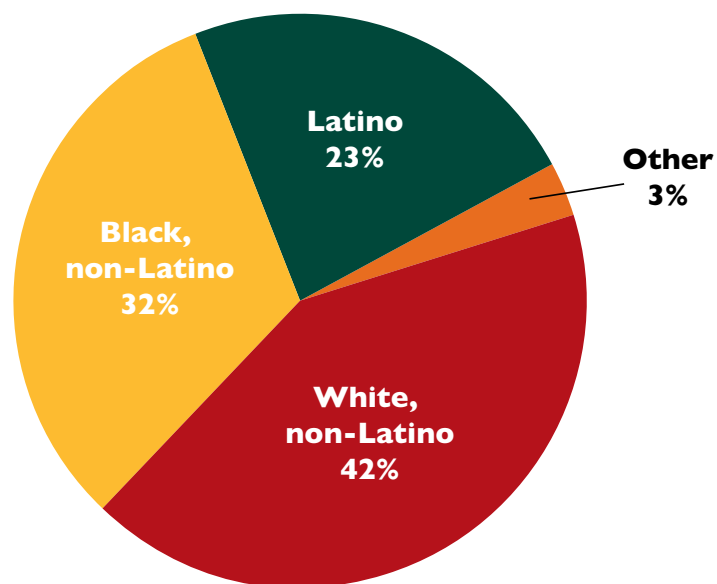
Gender: 16% male (5 of 31), 84% female (26 of 31)

### Race/ethnicity:

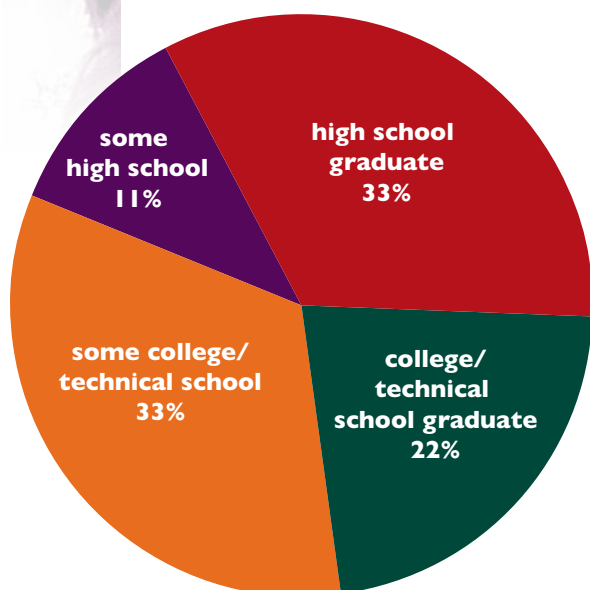
42% White, non-Latino (13 of 31)  
32% Black, non-Latino (10 of 31)  
23% Latino (7 of 31)  
3% Other (1 of 31)

Average age: 42  
(min: 16, max: 86)

### DECEDENT RACE/ETHNICITY



### DECEDENT EDUCATION LEVEL

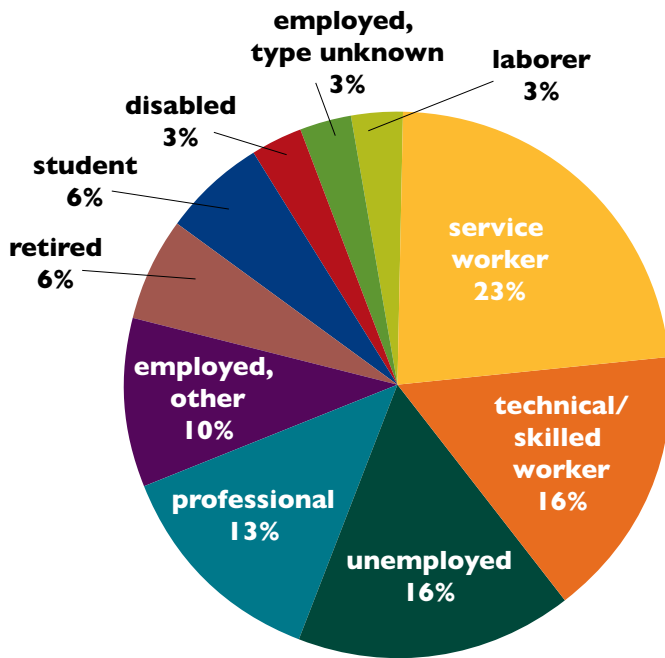


### Education:

33% high school graduate (6 of 18)  
33% some college/technical school (6 of 18)  
22% college/technical school graduate (4 of 18)  
11% some high school (2 of 18)



## DECEDENT EMPLOYMENT STATUS



### Employment type:

23%	service worker (7 of 31)
16%	technical/skilled worker (5 of 31)
16%	unemployed (5 of 31)
13%	professional (4 of 31)
10%	employed, other (3 of 31)
6%	retired (2 of 31)
6%	student (2 of 31)
3%	disabled (1 of 31)
3%	employed, type unknown (1 of 31)
3%	laborer (1 of 31)

## Relationship Characteristics

### 80% of decedents (24 of 30) had children:

33%	1 child (8 of 24)
29%	2 children (7 of 24)
21%	3 children (5 of 24)
8%	4 children (2 of 24)
4%	5 children (1 of 24)
4%	7 children (1 of 24)

Of the decedents with children, 71% (17 of 24) were known to have children with a partner other than the perpetrator.

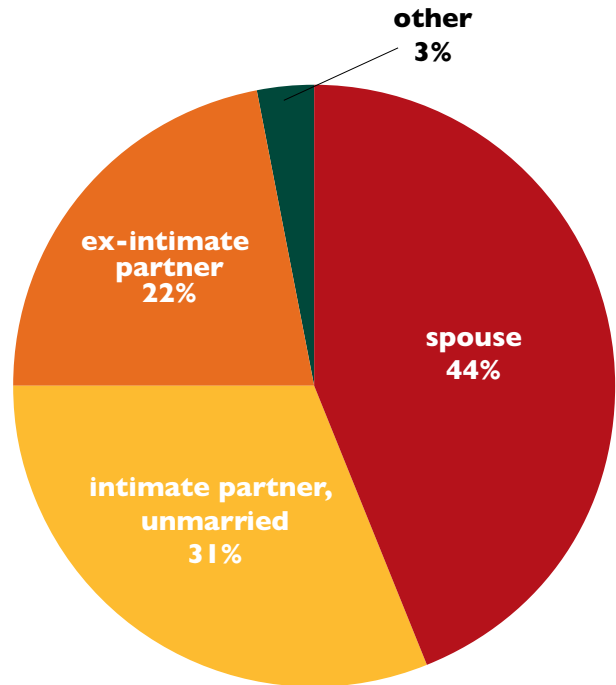
### Relationship of perpetrator to decedent:

44%	spouse (14 of 32)
31%	intimate partner, unmarried (10 of 32)
22%	ex-intimate partner (7 of 32)
3%	other (1 of 32)

### Average length of relationship:

11.4 years (min = .08,<sup>16</sup> max = 56)

## RELATIONSHIP TYPE



<sup>16</sup>The minimum length of separation was entered into the data collection tool as .08.

# LOCAL FATALITY REVIEW TEAM DATA ANALYSIS

## Prior living arrangements and separation:

- 59% (19 of 32) of couples were known to have previously lived together full time, 34% (11 of 32) of couples were known to have lived together “off and on,” and 6% (2 of 32) of couples were not known to have lived together during any time period.
- 67% (20 of 30) of couples were known to have been living together during the time of the incident.
- 33% (10 of 30), couples were known to be living separately during the time of the incident.
- 43% (13 of 30) of couples were known to be separated at the time of death (marital, separate households, or both).
- The average length of separation, when known, was approximately 0.5 years (min = 0, max = 3.5).
- There were known allegations of death threats made by 35% (11 of 31) of perpetrators towards the decedent prior to the incident.
- There was known harassment of the decedent by 29% (7 of 24) of perpetrators at the decedent’s workplace.

## CRIMINAL RECORDS

### Perpetrator:

- 55% (17 of 31) of perpetrators had a known criminal history of any kind, domestic violence related or otherwise, based on criminal records and narrative reports.
- 42% (13 of 31) of perpetrators had a known, non-domestic violence-related criminal history.
- 48% (15 of 31) of perpetrators had a known criminal history of domestic violence.
- 52% (16 of 31) of perpetrators had known prior reports to the police by the decedent, alleging domestic violence by the perpetrator.
- 55% (17 of 31) of family members reported knowing about prior incidents or prior threats of domestic violence on the part of the perpetrator.
- 32% (10 of 31) of perpetrators had a known criminal order of no contact issued against them.
- 32% (10 of 31) of perpetrators had a known permanent civil injunction for protection filed against them by the decedent.
- 19% (6 of 31) of perpetrators had a known permanent civil injunction for protection filed against them by someone other than the decedent.
- 0% (0 of 31) of perpetrators had a known civil injunction violation arrest identified by reviewers.

## Decedent:

- 16% (5 of 31) of decedents had a known history of domestic violence, based on criminal records and narrative reports.
- 7% (2 of 30) of decedents had a known criminal order of no contact order issued against them.
- 6% (2 of 31) of decedents had a known permanent injunction for protection filed against them by the perpetrator.

## Domestic Violence and Social Services

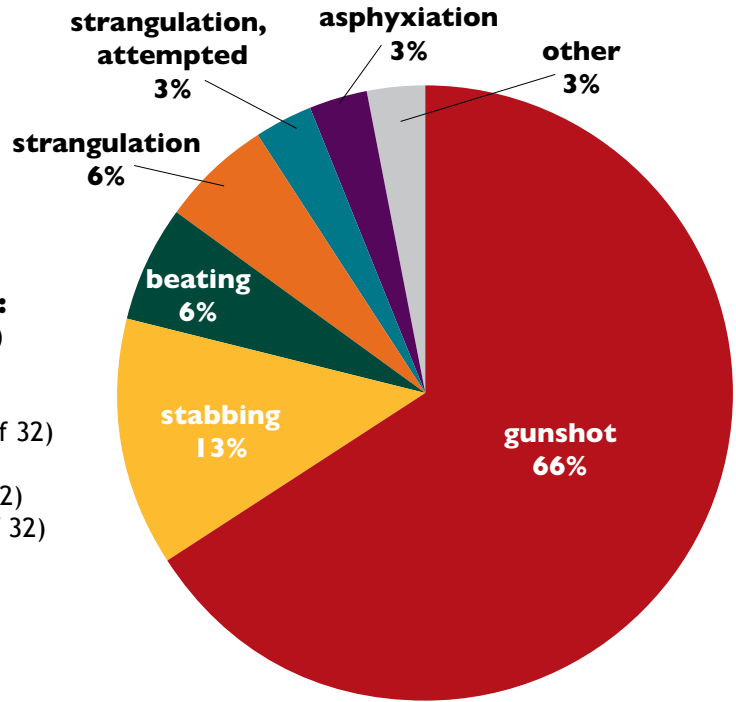
- 44% (14 of 32) of decedents or their family had known contact with the Department of Children and Families.
- 23% (7 of 31) of decedents had known contact with victim support services.
- 6% (2 of 31) had known contact with a certified domestic violence center.
- 3% (1 of 31) of decedents had known contact with a domestic violence program, other than a certified domestic violence program.
- 5% (1 of 20) of perpetrators with a prior history of domestic violence were currently or previously enrolled in a batterer intervention program (BIP).

## Characteristics of the Fatality

- 48% (15 of 31) of perpetrators died by suicide and an additional 14% (4 of 29) attempted but did not complete suicide.
- At the time of the fatality, there was known substance use by 33% of perpetrators. This information is based on self-reports by the perpetrator and medical toxicology reports. The breakdown is as follows:
  - 16% alcohol (3 of 19)
  - 11% drugs (2 of 19)
  - 16% drugs and alcohol (3 of 19)
  - 58% no known documented substance abuse (11 of 19)
- 23% (7 of 31) of fatalities had a secondary victim (i.e., a victim other than the decedent; does not include perpetrator suicides).
- There were known child witnesses in 28% (9 of 32) of the fatalities.

# LOCAL FATALITY REVIEW TEAM DATA ANALYSIS

## MANNER OF DEATH

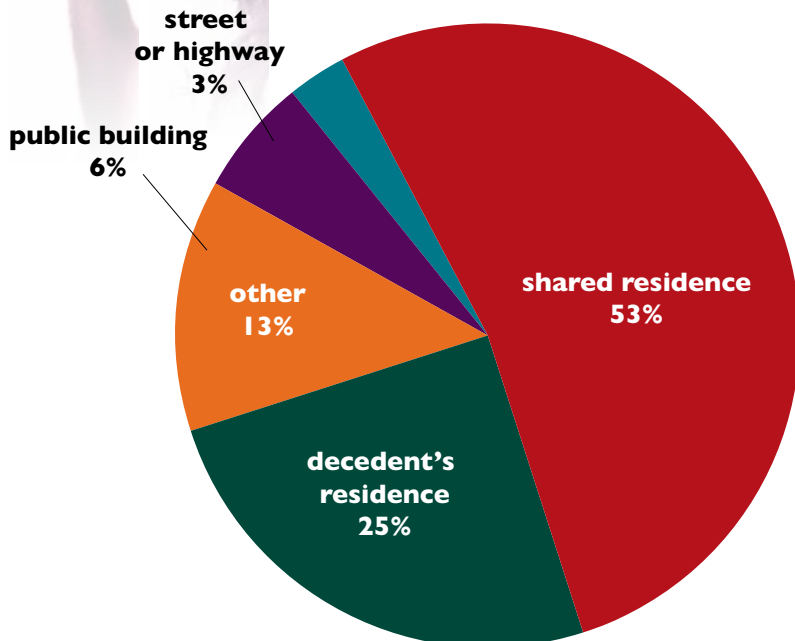


### Manner of death

#### (includes attempted):

66%	gunshot (21 of 32)
13%	stabbing (4 of 32)
6%	beating (2 of 32)
6%	strangulation (2 of 32)
3%	strangulation, attempted (1 of 32)
3%	asphyxiation (1 of 32)
3%	other (1 of 32)

## LOCATION OF HOMICIDE OR NEAR HOMICIDE

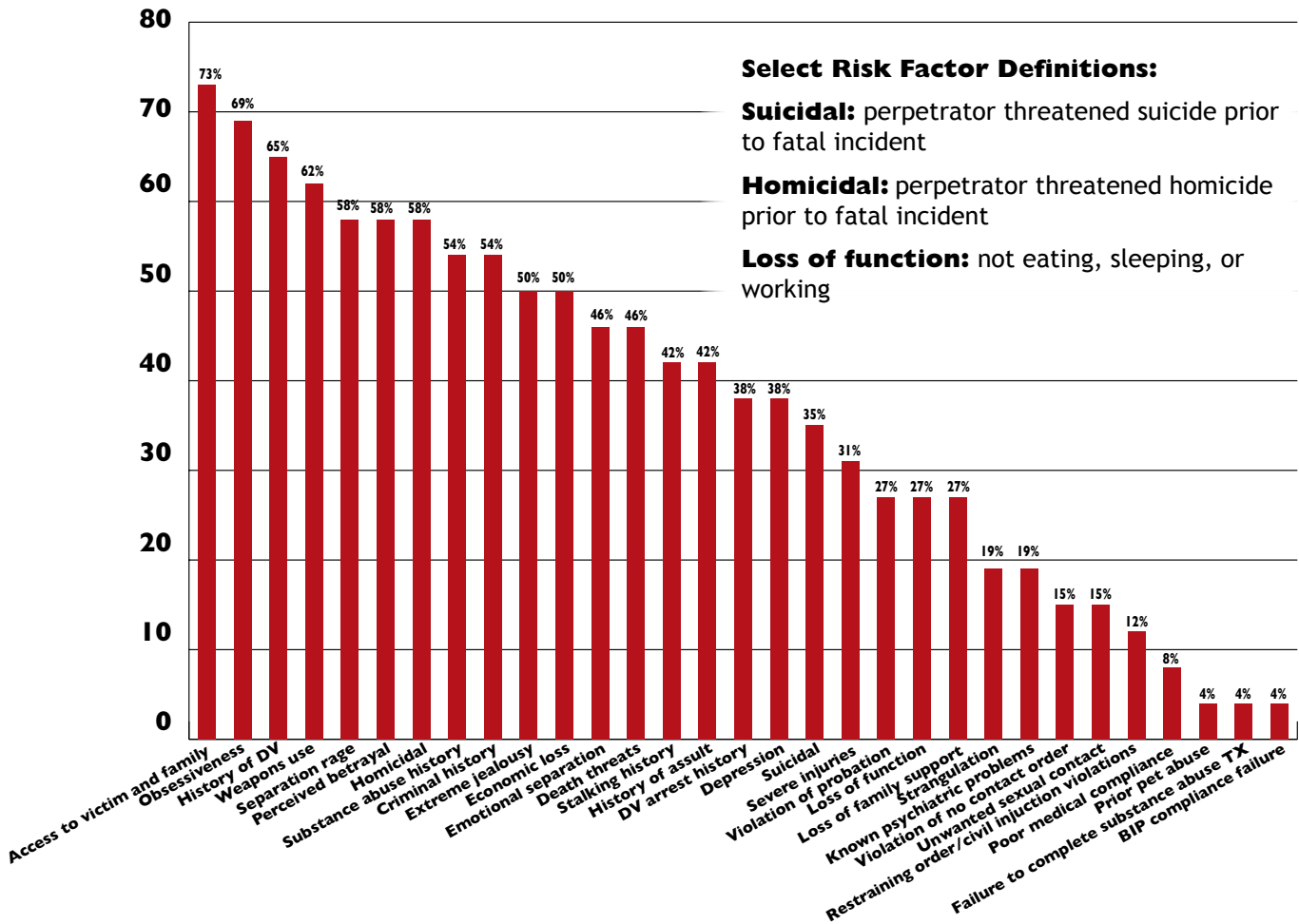


### Location of homicide or near homicide:

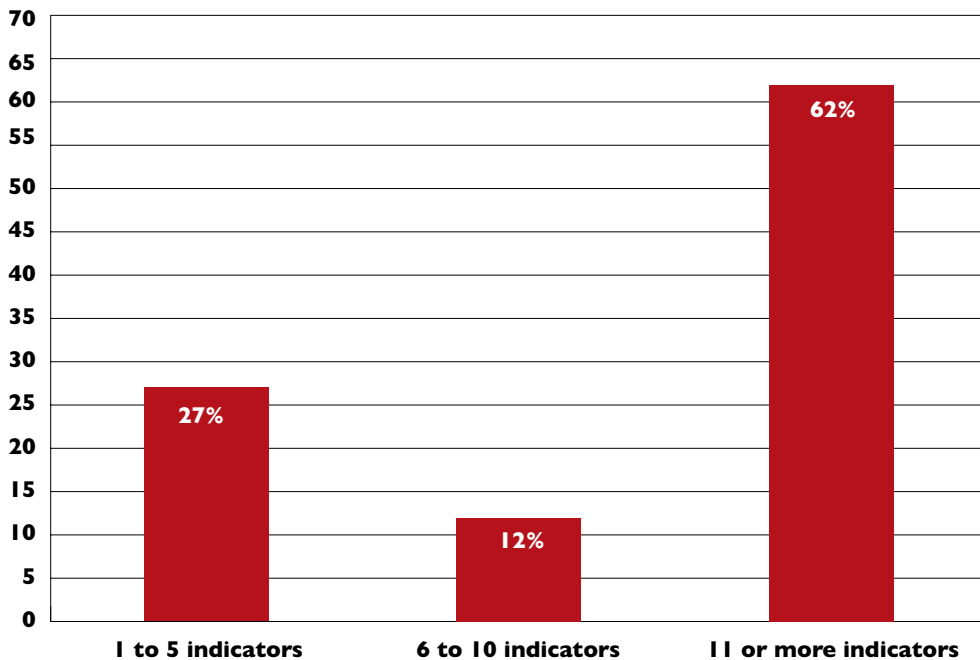
53%	shared residence (17 of 32)
25%	decedent's residence (8 of 32)
13%	other (4 of 32)
6%	public building (2 of 32)
3%	street or highway (1 of 32)



# BREAKDOWN OF KNOWN RISK FACTORS



## PERCENT OF CASES BY TOTAL KNOWN RISK FACTORS PRESENT



Many of this year's cases reflected significantly higher rates of multiple risk factors than in 2017, obsessiveness (69% in 2018 vs. 58% in 2016), use of weapons (62% in 2018 vs. 42% in 2017) and perceived betrayal (58% in 2018 vs. 50% in 2017).

# NOTABLE COMPARISONS

- The educational attainment of perpetrators relative to decedents remained comparable in the 2018 and 2017 reports. In 2018, reviewers identified 32% of perpetrators with less than a completed high school education compared to 11% of decedents. In 2017, 41% of perpetrators had not completed high school compared to 15% of decedents.
- The current reviews identified similarly high rates of known substance abuse by perpetrators (62% compared to 55% in 2017).
- The current reviews identified a substantial increase in the prevalence of known stalking by a perpetrator toward a decedent prior to the fatality (48% compared to 28% in 2017).
- The number of decedents known to have children with a biological father other than the perpetrator was higher in 2018 (71% compared to 65% in 2017).
- Reviews in the current report identified a similar prevalence of separation between the perpetrator and decedent at the time of death (43% compared to 42% in 2017).
- The current reviews identified a higher number of decedents reporting to law enforcement domestic violence by the perpetrator (52% compared to 31% in 2017).

# STATUS OF PRIOR RECOMMENDATIONS

## STATUS OF THE STATEWIDE TEAM'S 2016 AND 2017 RECOMMENDATIONS

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

**Status:** FCADV convened a child survivor workgroup in fiscal year 2016-2017 to identify and develop coordinated support services, including referrals and practices associated with children who witness or survive the domestic violence homicide of a parent. Representatives from the Arizona Child and Adolescent Survivor Initiative (ACASI) conducted training for the workgroup on the model ACSAI utilizes to provide trauma-informed services to children who have lost a parent as a result of intimate partner homicide (child survivors of IPH) and their current caregivers. The training included components related to building capacity to meet the needs of child survivors of intimate partner homicide through utilizing a coordinated community response.

FCADV and the workgroup designed and administered a survey to assess the capacity and needs of local communities to provide trauma-focused services to child survivors of IPH and their caregivers. The results of the survey will be applied to trauma-informed program development and training opportunities for increasing the capacity of local communities to respond to the needs of child survivors of IPH. FCADV was awarded funding through the Office of the Attorney General (OAG) to conduct training for advocates, mental health professionals, and community partners related to children who lost a parent(s) as a result of intimate partner homicide. Six regional trainings for local communities will be held in 2018. The training content includes information related to trauma-informed practices, the importance of establishing a collaborative network of service providers, and the skills necessary to provide counseling services to children and their caregivers to minimize the long-term effects of the complex trauma that occurs after the loss of a parent, sibling, or other loved one to intimate partner homicide.

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

**Status:** FCADV completed an online guide for media professionals that provides information related to reporting domestic violence incidents and homicides from a non-victim-blaming perspective. Such reporting helps dismantle the victim-blaming stigma associated with domestic violence and shifts the focus to the violence perpetrated by the abuser. The guide emphasizes the importance of utilizing language that identifies the violence as behaviors committed by the perpetrator against an intimate partner. Topics include the deconstruction of victim-blaming myths, how to appropriately cover intimate partner homicides, tips and best practices for reporting on domestic violence, and education of community members on the dynamics of intimate partner violence. The online guide includes local and state resources such as the Florida Domestic Violence Hotline and local certified domestic violence center hotline numbers that can be included by media outlets throughout the state when reporting on incidents of domestic violence.

# STATUS OF PRIOR RECOMMENDATIONS

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

**Status:** FCADV conducts an Annual Later in Life Abuse Institute for service providers to help formulate and hone their outreach and service strategies for this underserved and often vulnerable population. In addition, FCADV has partnered with the National Clearinghouse on Abuse in Later Life to implement Florida specific training for domestic violence advocates and allied service providers. Recently, FCADV conducted an Abuse in Later Life webinar with InVEST advocates in order to connect the InVEST model for identifying intimate partner violence with cases involving intimate partner abuse in later life. As a result of that webinar, FCADV developed a training curriculum that addresses barriers and needs of survivors of domestic violence in later life to assist domestic violence center advocates, law enforcement and other stakeholders with identifying additional risks that impact elders experiencing intimate partner violence.

FCADV was awarded a grant from the Federal Office on Violence Against Women's End Abuse in Later Life Program to develop a collaborative project with the certified domestic violence center, Help Now, in Osceola County. FCADV, Help Now, Osceola Council on Aging, Osceola County Sheriff's Office and the local Office of the State Attorney established a Coordinated Community Response dedicated to increasing services for domestic violence survivors in later life and holding perpetrators of elder abuse accountable for their violence. Project partners administered a survey to survivors of intimate partner violence and community partners, and held listening groups with adults in later life to assess the needs of elders and their knowledge of available support services. The listening sessions sought expertise of adults in later life to identify culturally appropriate messaging to promote awareness of abuse in later life services, particularly Help Now, the certified domestic violence center. Partners recognized the importance of connecting with the social networks of individuals in later life and expanded outreach to include faith-based organizations, as one venue where adults in later life are likely to gather. As a result, project partners strengthened relationships with local faith-based organizations to increase outreach to survivors in later life. In addition, the project increased access of domestic violence services for Spanish speaking survivors of abuse in later life through enhanced cultural and linguistic trainings for center advocates, law enforcement officers, social service providers, assistant state attorneys and other stakeholders. FCADV and Help Now conducted trainings in Osceola County on identifying and providing services and/or resources to survivors of later in life abuse.



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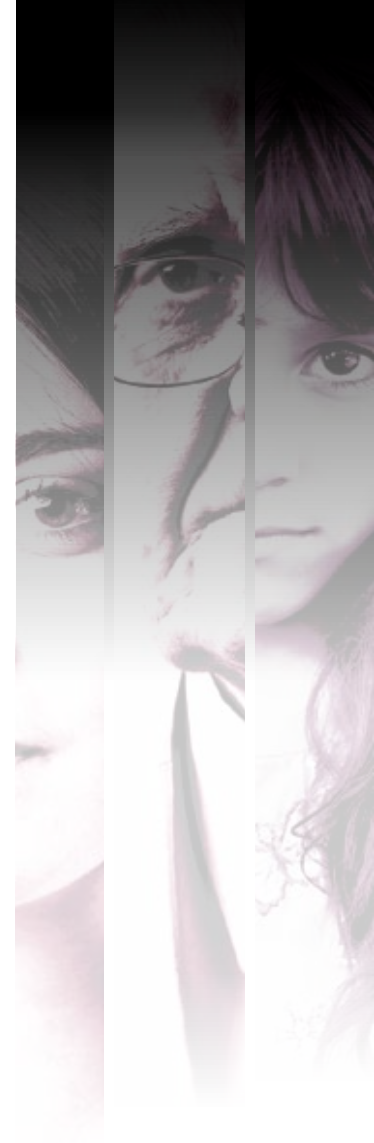
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# THANK YOU

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

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Bay  
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Broward  
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Lee  
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Pinellas  
Polk  
Santa Rosa  
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**FCADV**  
Florida Coalition Against Domestic Violence

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