

# The Faces of Fatality

Vol. II June 2012

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





**This report is dedicated to the 192 women, children and men who lost their lives during 2011 in Florida as a result of domestic violence, to their loved ones and to those who work every day to prevent these losses.**

*“Every domestic violence fatality represents a family grieving the loss of a loved one killed at the hands of a current or former family member. We must do all that we can to understand why these fatalities occur and identify strategies and responses to keep victims and their children safe and hold their batterers accountable. Domestic violence fatality review is an important tool in helping us find these answers. The statewide domestic violence fatality review team brings together a diverse group of professionals whose mission is to identify statewide trends and potential gaps in services, and to make recommendations for systemic change. The Office of the Attorney General is a proud partner in this vital process. Working together we can seek solutions to eliminate domestic violence fatalities.”*

—Attorney General Pam Bondi

*“Each and every domestic violence homicide is devastating and represents far more than a statistic in a report. These are people whose lives were taken at the hands of someone they once trusted, someone they once loved. These are families and friends dealing with the loss of a loved one, these are children left without a parent, and in some cases, without both parents. All deserve answers. Through the work of the statewide domestic violence fatality review team we are better able to understand these fatalities and look for the answers these families deserve. We are honored to partner with the Office of the Attorney General and work with the incredible professionals that make up the statewide team. Their dedication and commitment, coupled with the local domestic violence fatality review teams will make a difference in the work to end domestic violence deaths.”*

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

In 2009, then Attorney General Bill McCollum established Florida's first statewide domestic violence fatality review team<sup>1</sup> in response to the 2009 Florida Department of Law Enforcement (FDLE) report reflecting a 15.6% increase in domestic violence murders and a 71.4% increase in domestic violence manslaughter, while all other murders decreased by 12.9%. The team, co-chaired by the Florida Coalition Against Domestic Violence (FCADV) and the Office of the Attorney General, and in collaboration with the Florida Department of Children and Families (DCF), brought together a diverse group of professionals who represent the complexity of domestic violence and the agencies that victims and perpetrators may encounter. The Attorney General charged the team to both conduct reviews of domestic violence fatalities and near fatalities, and analyze the data collected by local fatality review teams. The team's mission is to identify statewide trends, service provision gaps and make recommendations for systemic change.

Attorney General Pam Bondi, understanding the team's critical mission, maintained her office's strong support of and participation on the team. The current statewide team includes representatives of domestic violence centers, legal and direct service providers, state agencies, a faith-based organization, probation, parole, corrections, law enforcement, health care, the military, the court system, prosecutors, the defense bar and a survivor. The team met four times in 2011-2012, including a joint meeting with the State Child Abuse Death Review Committee.

Domestic violence fatality review is recognized as an important tool used to identify gaps in service delivery and potential systemic breakdowns, as well as to create strategies that improve and increase responses to keep victims and their children safe and hold batterers accountable, with the ultimate goal of preventing domestic violence homicides. A key component of fatality review, designed to ensure open and honest dialogue among team members, is the "no blame, no shame" philosophy that recognizes no one system can prevent or is responsible for a homicide - that responsibility lies solely with the perpetrator.

This is the second report produced by the statewide domestic violence fatality review team.<sup>2</sup> It is designed to provide policy makers, state and community leaders and collaborative partners with findings and recommendations based on an analysis of data from reviews by local fatality review teams, as well as an in-depth case study conducted by the statewide team.

One of the challenges acknowledged in the first Faces of Fatality report was the limitations regarding uniform data collection and analysis of local team reviews. This year, a new online data collection tool was implemented that prompted teams to provide complete and uniform information through an online questionnaire with common definitions of particular data requested. This online system provided a more efficient compilation of those reviews and a far more effective means of analyzing the data for this report.

During a 12 month period, local teams submitted 64 reviews of intimate partner homicides and near homicides that occurred between 2005 – 2011.<sup>3</sup> The case studied by the statewide team was a 2010 stalking murder/suicide that occurred five days after the victim's *ex parte* petition for an Injunction for Protection Against Dating Violence was denied, and the perpetrator in the case had been served with notice of a hearing in the court to determine whether to issue a final injunction. The case study turned out to be particularly timely, as the recently released 2011 FDLE Uniform Crime Report<sup>4</sup> reflected that domestic violence simple stalking increased 65.1%, and stalking is widely recognized as an underreported offense. The magnitude of the increase is of particular concern, as stalking is a common precursor to domestic violence/dating violence homicide.<sup>5</sup>

Throughout the entire case study, and during its review and analysis of local fatality review team cases, the statewide team complied with statutory mandates regarding fatality review and victim confidentiality requirements.<sup>6</sup> With the information acquired through the data analysis and case study, the statewide team has made recommendations to address some of the key findings included in this year's Faces of Fatality, Volume II.

<sup>1</sup>In 2000, the Florida Legislature passed laws governing the establishment of domestic violence fatality review teams. See Florida Statute sections 741.36 and 741.365.

<sup>2</sup>The first report, Faces of Fatality, is available at [www.fcadv.org](http://www.fcadv.org).

<sup>3</sup>In many cases, local teams review homicides only after the case is completely closed, thus there may be a delay of several years between the homicide and the fatality review.

<sup>4</sup>[www.fdle.state.us/Content/FSAC/UCR/UCR-Home.aspx](http://www.fdle.state.us/Content/FSAC/UCR/UCR-Home.aspx)

<sup>5</sup>The FDLE reports that in 2011, total reported domestic violence incidences in Florida decreased 1.5%. For the past two years, domestic violence murder and manslaughter have trended downward. (FDLE's Uniform Crime Report indicated the following number of domestic violence murder/manslaughter by year: 2008-194, 2009-232, 2010-210, 2011-192) While most all other criminal offenses have declined, stalking is the notable exception with simple stalking experiencing a 65.1% increase and aggravated stalking a 1.4% increase.

<sup>6</sup>Florida Statute sections 741.316, 741.3165, and 39.908.



### Findings

This year's report includes an analysis of data collected by local fatality review teams between April 2010 and April 2011. Teams submitted completed reviews of domestic violence homicides and near homicides that occurred between 2005 and 2011. In total, teams submitted 64 complete reviews that are included in the analysis. Findings from this year's data collection continue to highlight several consistent aspects of victim and perpetrator profiles and factors that suggest a heightened risk of lethality.

- The perpetrators were predominantly male (83%) and had prior criminal histories, generally (60%) and for domestic violence specifically (48%).
- 28% of perpetrators had a known "do not contact" order filed against them previously, of those with prior domestic violence criminal history 20% had been enrolled in a Batterers' Intervention Program (BIP).
- The perpetrators and decedents were: White (48% and 55%, respectively), Black (36% and 23%, respectively) and Hispanic (16% and 17%, respectively).
- The decedents were predominantly female (83%) and at some point lived with their abuser full time (67%). At the time of the incident, 30% of the decedents were separated from the perpetrator.
- 63% of decedents had children and of those, 50% had a child from a different relationship.
- 35% of the decedents had previously reported domestic violence to the police. In 29% of the cases, death threats made by the perpetrator were reported.
- Substance abuse by the perpetrator was identified in 44% of the cases and mental health disorders in 28%.
- Perpetrators committed or attempted to commit suicide in 59% of the cases.
- In 25% of cases there was known contact between the Department of Children and Families (DCF) and the decedent or her/his family.
- 16% of incidents included a collateral victim (i.e., a victim other than the decedent; does not include perpetrator suicides).



- There were known child witnesses in 13% of the cases.
- In 21% of cases (13 of 62) there were known allegations by the decedent of stalking on the part of the perpetrator.
- Based on the case study conducted by this team, *pro se* petitioners filing for civil injunctions for protection may lack understanding of the importance of providing the court with all incidents of violence, threats and stalking committed by the respondent to ensure that the court has all relevant information when determining whether to issue the *ex parte* injunction.
- Based on the case study conducted by this team, when the court denies an *ex parte* injunction for protection petition and sets a hearing on the injunction, the petitioner is at a heightened risk of escalating violence because when the respondent is served with notice of the hearing, there is a period of time where the respondent knows the petitioner is seeking separation from the perpetrator, but there is no injunction in place to protect the petitioner.

The data collected continues to underscore the salience of several factors typically associated with domestic violence escalation. Apart from separation status, a substantial proportion of reviews uncovered evidence of: perceived betrayal (47%), obsessiveness (42%), extreme jealousy (38%), death threats (33%), separation rage (30%), and economic loss (23%). The majority of cases reviewed had a multitude of these factors present. For example, in 45% of the incidents, reviewers found evidence of between 6 and 10 lethality risk factors, and in an additional 26%, reviewers found evidence of more than 11 lethality risk factors.<sup>7</sup>

## Comparisons

Comparisons to the data in the 2011 report reveal a number of similarities. The breakdown of gender for perpetrators and decedents was generally the same, as were the age breakdowns and the relative frequencies for the different manner-of-death categories. This year's data, however, also revealed several notable differences. Specifically, a smaller proportion of perpetrators and decedents identified as Hispanic and a higher number identified as White. There was a substantially higher percentage of couples in the cases reviewed who were living together at the time of the incident. Analysis also indicated a much higher percentage of family and friend knowledge about the occurrence of domestic violence prior to the homicide. Perpetrators, in this year's reviews, more frequently had "do not contact" orders, were more often enrolled, at some point, in BIP, and they committed suicide twice as frequently as the perpetrators in the cases reviewed last year.

**Perpetrators in  
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<sup>7</sup> See lethality risk factor table on page 16.

## RECOMMENDATIONS

1. Given the findings in this report and the 2011 FDLE data reflecting a 65.1% increase in domestic violence simple stalking, there is a critical need to provide specialized training to stakeholders and increase public awareness about the dangers associated with stalking behavior and the legal rights of and protections available to stalking victims. The following actions would address this need:

### Public Awareness

- Establish an official Florida observance of National Stalking Awareness Month in January of each year through the Executive Office of the Governor and the Office of the Attorney General. This statewide observance will increase community awareness regarding the dangers of stalking and cyberstalking, including the potential risks when accessing social networking websites, as well as the legal rights of and protections available for victims.
- FCADV, through its current collaboration with the Department of Education, should include specific information relating to stalking and cyberstalking in the dating violence curriculum designed for middle and high school students.
- FCADV should partner with the Department of Health, Office of the Attorney General and other state and local agencies to identify appropriate forums both statewide and in local communities to increase awareness about stalking and cyberstalking and the legal rights of and protections available to victims.

### Training

- FCADV should coordinate with the Office of the Attorney General, FDLE, the Florida Prosecuting Attorney's Association, local law enforcement agencies and others to offer specialized training on the elements of and heightened risks associated with stalking and cyberstalking, as well as the legal rights of and protections available to victims. State and local agencies and non-governmental organizations receiving this training should include: the Florida Parole Commission, the Department of Corrections, misdemeanor probation departments, certified domestic violence centers, law enforcement, emergency responders, victim advocates, substance abuse and mental health providers, supervised visitation providers, prosecutors, child welfare attorneys and family law attorneys, adult and child protective investigators, judges and court personnel, and clerks of court. The training curriculum should build upon FCADV's current safety and technology training that addresses the technology batterers use to cyberstalk victims such as location tracking, computer and cell phone monitoring applications, and Caller ID spoofing. The curriculum should also include information about the new civil injunction for protection against stalking and cyberstalking enacted by the 2012 Legislature and effective October 1, 2012.

2. *Pro se* petitioners for injunctions against domestic, dating and sexual violence and stalking need information about and assistance with completing petitions for injunctions for protection that provide sufficient information to ensure that the court has all relevant information when determining whether to issue the *ex parte* injunction.





- FCADV should collaborate with the Association of Court Clerks, local clerk's offices, local domestic violence centers and others to develop informational brochures and other methods to increase awareness regarding assistance for petitioners to complete petitions for injunctions for protection that is available in their local communities. Such assistance is currently provided by certified domestic violence centers, law enforcement and state attorney victim advocates, clerk's offices and others, but *pro se* petitioners are often unaware of these resources.
  - The statewide domestic violence fatality review team will identify and review available software and other technological advances that could assist *pro se* petitioners in completing injunctions for protection.
3. During the next year, the statewide domestic violence fatality review team should obtain information and feedback from survivors, victim advocates, judges and court personnel, state and local service providers and others to develop specific recommendations to address the heightened danger to victims when the court denies an *ex parte* petition and sets a hearing, with notice to the respondent, to determine whether to issue a final injunction.<sup>8</sup>
  4. The statewide domestic violence fatality review team should form a subcommittee to meet at least once a year with the State Child Abuse Death Review Committee to discuss the overlapping issues between domestic violence and child abuse, including the feasibility of conducting a joint review of an appropriate case.
  5. Based on the finding in this report that 63% of decedents had children, as well as research demonstrating the long-term adverse impacts on surviving children and the current lack of resources to address their needs (Marilyn Armour, *Domestic Fatalities: The Impact on Remaining Family Members*, [www.thepressatcsufresno.org](http://www.thepressatcsufresno.org)), this team renews its recommendation from 2011 that DCF and child welfare community based providers should develop local agreements with law enforcement to ensure that they are notified when there is a domestic or dating violence fatality and there are surviving children. If the surviving children become dependent in the child welfare system, DCF should ensure that they are provided with appropriate services while in foster or relative care to address their trauma. In addition, child protective investigators should be trained and required to provide appropriate service referrals for surviving children who do not enter the child welfare system but are placed with family members or other caregivers.
  6. Based on the finding in this report that evidence of substance abuse was identified in 44% of the perpetrators, this team renews its recommendation from 2011 that judges, service providers and other personnel involved with Drug and Dependency courts should receive specialized training on the unique correlation between substance abuse and domestic violence, and consult with and include domestic violence advocates familiar with substance abuse issues in developing case plans.

**In an effort  
to ensure  
implementation,  
this team will  
follow up with  
and report on the  
status of each  
recommendation  
in its 2013 report.**

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<sup>8</sup> Florida Statute section 741.30 (5)(b), requires the court to set a hearing when the only basis for denial of a petition for injunction against domestic violence is no appearance of immediate and present danger of domestic violence.

# CASE STUDY

This case study is based on a review of law enforcement reports, newspaper articles, and a telephone interview with a relative of the perpetrator.

In August 2010, B.R., age 22, was murdered by a former intimate partner, C.S. age 27, who then took his own life.<sup>9</sup> The murder/suicide occurred five days after B.R.'s *ex parte* petition for an Injunction for Protection Against Dating Violence was denied, and C.S. had been served with notice of a hearing for the court to determine whether to issue a final injunction.

## Background on victim and perpetrator

B.R. moved to Florida in 2007 to attend school. She graduated in May 2010 and was employed at the time of her murder.

C.S. was born the same year his father died. As a young child his mother was unable to care for him, and he was raised by his maternal grandmother. For a brief time as a teenager, C.S. was placed in foster care because he would not go to school. According to his relative, C.S. was a good student but did not want to attend school because he was being bullied. C.S. completed his GED and a technical course. In 2001, he began working and remained employed by the same company until the murder/suicide. C.S.'s supervisor reported that he was a very good worker, never called in sick and was very quiet.

## Relationships

In January 2010, B.R. and C.S. met through an online social networking site and began dating in February 2010. B.R. ended the relationship in April 2010, but they continued to remain friends and were occasionally intimate. B.R.'s roommate reported that C.S. continued to contact B.R. saying he wanted to be with her, and that she thought C.S. was obsessed with B.R.

In April 2010, C.S. met another woman through a different online social networking site and they began dating. She told law enforcement that they went out together every week and that C.S. made videos of them having sex on his cell phone. In her statement to police, she stated that C.S. did not drink or use drugs, and that they both were seeing other people but he never mentioned B.R. by name. She said she never saw any weapons and he

did not seem violent. C.S. did tell her that he had been in trouble with the law as a teenager and was having problems with a co-worker. She eventually discovered that C.S. was on a large number of other social networking sites and that he was seeing several other women, sometimes just hours before they went out together. She said that in August 2010, she needed a roommate and C.S. asked about moving in with her. When they went out the day before the homicide, C.S. told her he wanted to move in as her boyfriend, and that he became angry and "started acting jealous" when she said he could move in as a roommate, not as her boyfriend.

## Stalking

In August 2010, C.S. began following B.R. to her apartment complex, and began sending her photographs and videos of him having sex with other women. He sent her texts, telling her he could not live without her and that he had nothing else to live for. B.R. told C.S. that she wanted no further contact with him and blocked his number, but his sexually explicit messages continued. During the police investigation, one of B.R.'s coworkers reported that C.S. made multiple threats to kill himself or B.R. if he could not be with her.

Eight days prior to the homicide, B.R. called the police because C.S. was watching her from his car in the parking lot of her apartment. She told officers that his presence was "weird" but said she was not afraid, just that she thought he was acting "creepy." B.R. advised police about the text messages and images she received from C.S., but did not want to pursue charges. She asked the officers to tell him to leave and not to contact her again. The officers escorted C.S. off the property and told him if he returned or continued to text or call her he would be charged with a crime.

The following day B.R. went to the police department to report that C.S. was stalking her. The officer called C.S. and told him that charges had been filed against him and not to contact B.R. The officer reported that C.S. became upset and denied everything. B.R. completed a victim statement reporting that C.S. told her he would not stop texting or following her until she went back to him or he found out she was not seeing other men. She wrote that she had repeatedly told him to stop contacting her, but he continued to send texts that were sexually explicit and stating he could not



live without her and had nothing else to live for. C.S. told her he saw her leave another person's apartment and accurately described what she was wearing. B.R. further wrote that she started receiving text messages from strangers responding to an advertisement on Craigslist under "Intercourse." The ad included her cell phone number and it said she was "all about fun and games." She began to receive voice mail messages that sounded like heavy breathing. She then received another text that she had another ad placed on Craigslist. B.R. stated that she believed C.S. was responsible for placing the ads. In her statement, B.R. said that she did not feel safe and wanted to press charges or file for an injunction.

B.R. filed an *ex parte* petition for a temporary Injunction for Protection Against Dating Violence on August 23, 2010. In the petition she stated that she was afraid to come out of the house because C.S. watched the apartment, followed her and made harassing phone calls. She further stated that she had "been violated on the internet," but did not include details regarding the number and content of the texts and voicemails, including the threats, she received from C.S. B.R.'s *ex parte* petition was denied the next day, a court date was set for a hearing on a final injunction, and C.S. was served with the petition and notice of hearing. The following day, police met B.R. to sign the stalking complaint. She told the officer that she had not heard from C.S. since they called him and that they must have "scared him off." She did not tell the officer that her petition for a temporary injunction had been denied.

### The Homicide/Suicide

The day before the homicide, C.S. checked into the motel where their bodies would later be found. That night he went out with two other women. One of the women reported that he told her he had to pick up a friend from work at 6:00 a.m.

While getting ready for work the morning of the homicide (at 4:45 a.m.), B.R.'s roommate

heard her say "Oh my God, really!" The roommate thought B.R. was either on the phone or responding to a text. B.R. then told her she was leaving for work and would see her there. The roommate became concerned when B.R. did not arrive at work, after returning to their apartment to look for her and attempting to call her cell phone, at 7:58 a.m. she called the police. B.R.'s parents called law enforcement from their home state expressing their concern that it was unlike her not to go to work without calling her employer.

Law enforcement issued an alert for B.R.'s car and tag number and requested a "ping" of her cell phone. While no one had been able to reach her, there were two hits from the "ping" both from that morning – and from within the county. Law enforcement continued to search for both B.R. and C.S. Law enforcement found C.S.'s car in the parking lot of an apartment complex in the area. The next morning the motel manager discovered B.R. and C.S.'s bodies in a room in the motel C.S. checked into the day before, when there was no response to calls regarding checking out. C.S., who tested positive for cocaine, apparently shot and killed B.R. and then shot and killed himself. B.R.'s car was in the motel parking lot.

### Factors in the case that often indicate increased risk include:

- B.R. had broken off the relationship
- C.S. stalked and cyberstalked B.R.
- B.R. attempted to make the separation permanent by reporting the stalking to police and filing a petition for an Injunction for Protection Against Dating Violence
- C.S. was reportedly obsessed with B.R.
- C.S. threatened to kill B.R. and himself if she would not resume the relationship
- C.S. had used cocaine prior to the homicide

<sup>9</sup>Out of respect for the victim, the perpetrator and their families, the initials of the victim and perpetrator have been changed.

# LOCAL FATALITY REVIEW TEAM DATA ANALYSIS

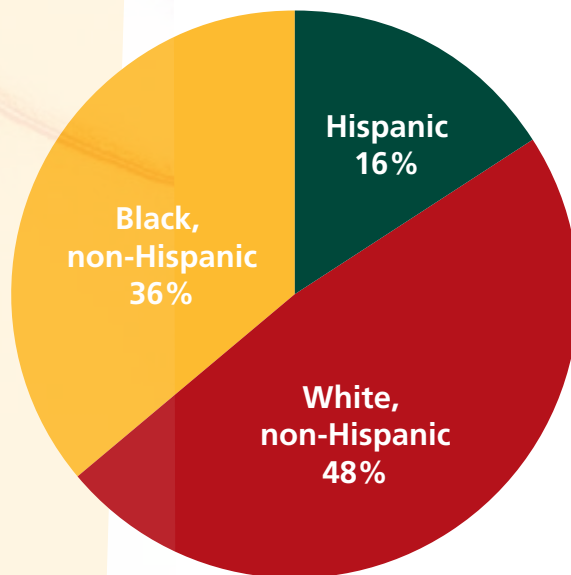
Local fatality review teams submitted 64<sup>10</sup> reviews of fatal or near-fatal domestic violence incidents in Florida that occurred between 2005 and 2011 (see table below).<sup>11</sup> For each incident, local teams reviewed and provided information about the perpetrator, the decedent, their relationship, their criminal records, domestic violence histories and services, the incident, and various risk factors. This report provides a presentation of those data points and summary statistics for each of these categories, followed by a brief description of a comparison between this year's data and the information that was collected for the 2011 report.

YEAR OF INCIDENT	# OF REVIEWS
2005	3
2006	1
2007	8
2008	4
2009	15
2010	25
2011	8

## Perpetrator Characteristics<sup>12</sup>

Gender: 83% male (53 of 64), 17% female (11 of 64)

### PERPETRATOR RACE-ETHNICITY



#### Race/ethnicity:

48% White, non-Hispanic (29 of 61)  
 36% Black, non-Hispanic (22 of 61)  
 16% Hispanic (10 of 61)

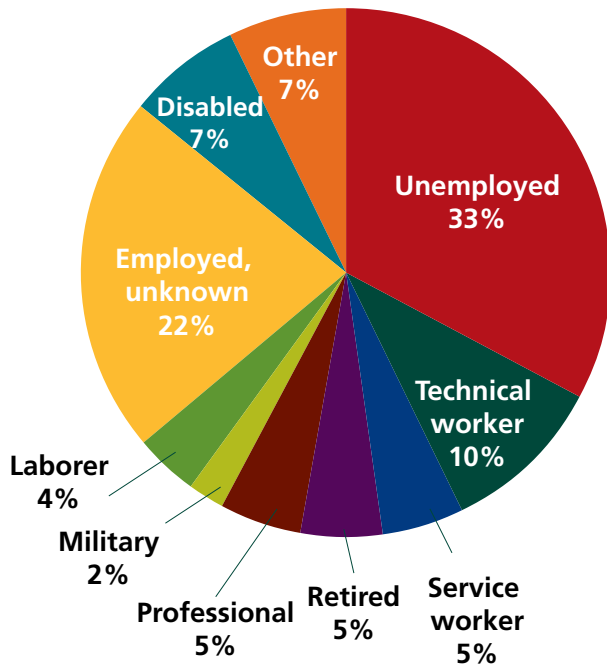
Average age: 42 (youngest: 21, oldest: 86)

<sup>10</sup> The data are based on the 64 reviews submitted by local fatality review teams. However, in some instances, statistics are based on different totals either due to non-applicability or missing information in reviews. We include the total number of cases used to calculate each statistic in parentheses.

<sup>11</sup> In 8 cases, the "decedent" did not die, but for simplicity, we include information about those victims under the "decedent" category.

<sup>12</sup> The review questionnaire includes questions that are used to distinguish whether the perpetrator was an abuser or was an abused victim who acted in self-defense. There were no cases submitted, however, that involved a "perpetrator" who was actually a domestic violence victim acting in self-defense.

## PERPETRATOR EMPLOYMENT STATUS



### Employment type:

33%	unemployed (19 of 58)
10%	technical/skilled worker (6 of 58)
7%	disabled (4 of 58)
7%	other (4 of 58)
5%	service worker (3 of 58)
5%	retired (3 of 58)
5%	professional (3 of 58)
4%	laborer (2 of 58)
2%	military (1 of 58)
22%	employed, type unknown (13 of 58)

## Other known perpetrator characteristics:

- In 44% of cases (28 of 64), reviewers found evidence of substance abuse of some kind based on various sources (e.g., DUI records, police reports, substance abuse services, personal narratives from self, family, friends, or co-workers).
- In 28% of cases (18 of 64), reviewers found evidence of medically diagnosed mental health disorders.
- In 33% of cases (21 of 63), reviewers learned that the perpetrator was known, by family or friends, to carry or possess a weapon.
- In 5% of cases (3 of 63), reviewers found evidence of prior animal abuse on the part of the perpetrator.
- 6% of perpetrators (4 of 64) had a known history of suicide attempts.

## Decedent Characteristics

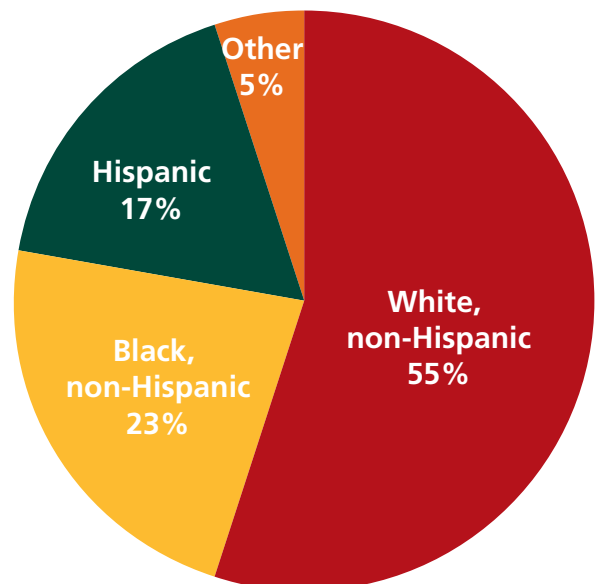
Gender: 17% male (11 of 64), 83% female (53 of 64)

### Race/ethnicity:

55%	White, non-Hispanic (35 of 64)
23%	Black, non-Hispanic (15 of 64)
17%	Hispanic (11 of 64)
5%	Other (3 of 64)

Average age: 41 (youngest: 11, oldest: 86)

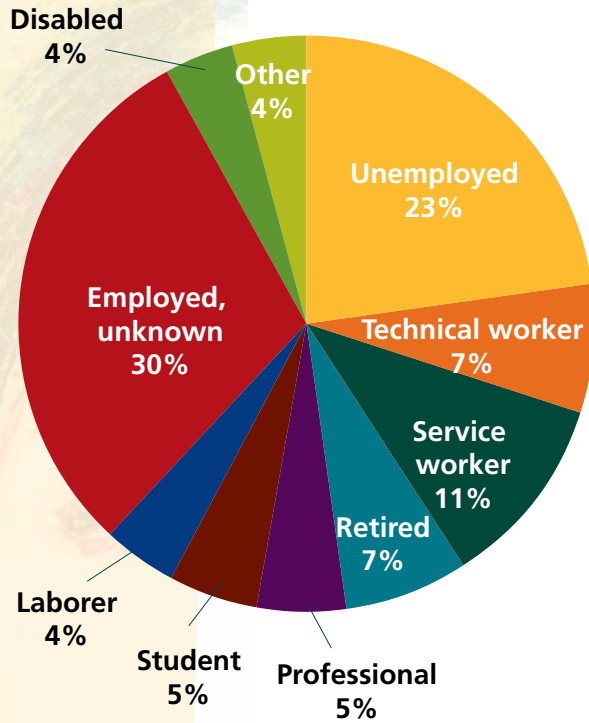
## DECEDENT RACE-ETHNICITY





# LOCAL FATALITY REVIEW TEAM DATA ANALYSIS

## DECEDENT EMPLOYMENT STATUS

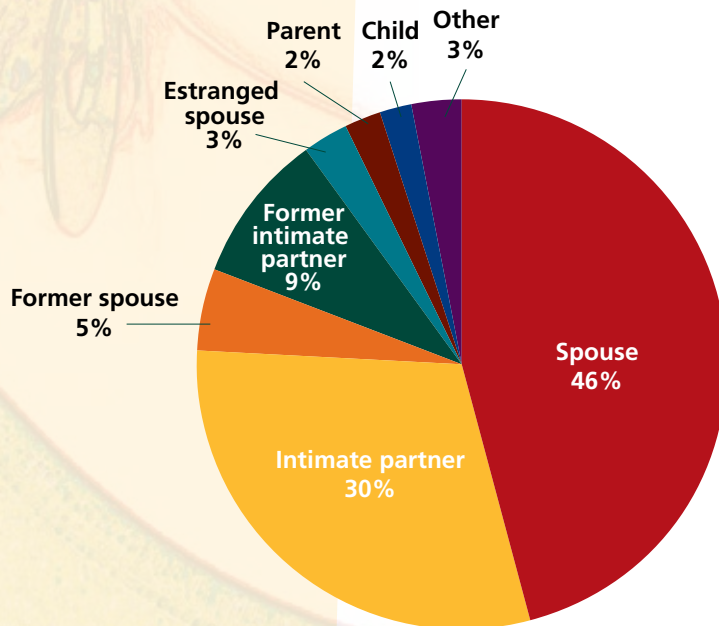


### Employment type:

23%	unemployed (13 of 57)
11%	service worker (6 of 57)
7%	retired (4 of 57)
7%	technical/skilled worker (4 of 57)
5%	student (3 of 57)
5%	professional (3 of 57)
4%	laborer (2 of 57)
4%	disabled (2 of 57)
4%	other (2 of 57)
30%	employed, type unknown (18 of 57)

## Relationship Characteristics<sup>13</sup>

### RELATIONSHIP TYPE



### Relationship of perpetrator to decedent:

46%	spouse (30 of 64)
30%	intimate partner (non-spouse) (19 of 64)
9%	former-intimate partner (6 of 64)
5%	former-spouse (3 of 64)
3%	estranged spouse (2 of 64)
2%	parent (1 of 64)
2%	child (1 of 64)
3%	other (2 of 64)

Mean length of relationship: 11.86 years

<sup>13</sup> Some local fatality review teams review only intimate partner homicides and not deaths of other household members.

## Relationship Characteristics

### **63% of decedents (38 of 60) had children:**

- 1 child (24 of 38)
- 2 children (10 of 38)
- 3 children (2 of 38)
- 4 children (2 of 38)

Of decedents with children, 50% (18 of 36<sup>14</sup>) had children outside of their relationship with the perpetrator. The perpetrator was the natural parent of all of the decedent's children in 50% of cases reviewed where the decedent had children.

### **Prior living arrangements and separation:**

- In 67% of cases (43 of 64), couples had previously lived together full time, 25% (16 of 64) had lived together "on and off," and 5% never lived together (3 of 64).
- Of couples who had previously lived together full time (43 of 64) or "on and off" (16 of 64), 66% (39 of 59) were known to be living together at the time of the incident and 27% (16 of 59) were known not to be living together at the time of the incident.
- Of those same couples, reviewers found evidence of separation (marital, separate households, or both) in 32% of cases (19 of 59).
- The average length of separation, when known, was approximately 1.13 years (min=0-just separated, max=12).

### **Threats, Stalking and Harassment:**

- In 29% of cases (18 of 63) there had been known allegations by the decedent of death threats made by the perpetrator against the decedent prior to the incident.
- In 21% of cases (13 of 62) there had been known allegations by the decedent of stalking on the part of the perpetrator.
- In 10% of cases (6 of 63) there had been known harassment of the decedent, by the perpetrator, at the decedent's workplace.

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<sup>14</sup> This number does not include two cases where the decedent had children, but it is not indicated if the children were with the perpetrator.

## Criminal Records

### Perpetrator:

- 40% (25 of 63) of perpetrators had a known, non-domestic violence, criminal history.
- 48% (30 of 63) of perpetrators had a known criminal history of domestic violence.<sup>15</sup>
- In 35% of cases (22 of 63), there were known prior reports to the police by the decedent, alleging domestic violence by the perpetrator.
- In 56% of cases (35 of 63), family members reported knowing about prior incidents or prior threats of domestic violence on the part of the perpetrator.
- 60% (38 of 63) of perpetrators had a known criminal history, domestic violence-related or otherwise, based on criminal records and narrative reports.
- In 28% of cases (17 of 60) there was a known “do not contact” order issued against the perpetrator.
- In 8% of cases (5 of 62) there was a known permanent injunction filed against the perpetrator by the decedent.
- In 13% of cases (8 of 62) there was a known permanent injunction filed against the perpetrator by someone other than the decedent.
- In 3% of cases (2 of 63) there was a record of an arrest for violation of an injunction.

### Decedent:

- 11% of decedents (7 of 62) had a known history of domestic violence, based on criminal records and narrative reports.
- In 9% of cases (5 of 55) there was a known “do not contact” order issued against the decedent.
- In 5% of cases (3 of 63) there was a known permanent injunction filed against the decedent by the perpetrator.

## Domestic Violence and Social Services

- In 25% of cases (16 of 63), there was known contact between DCF and the decedent or her/his family.
- In 11% of cases (7 of 62), there was known contact between the decedent and victim support services.
- In 5% of cases (3 of 63), there was known contact between the decedent and a domestic violence shelter.
- 21% of perpetrators (7 of 33) with a prior history of domestic violence were currently or had been previously enrolled in a Batterers’ Intervention Program (BIP).

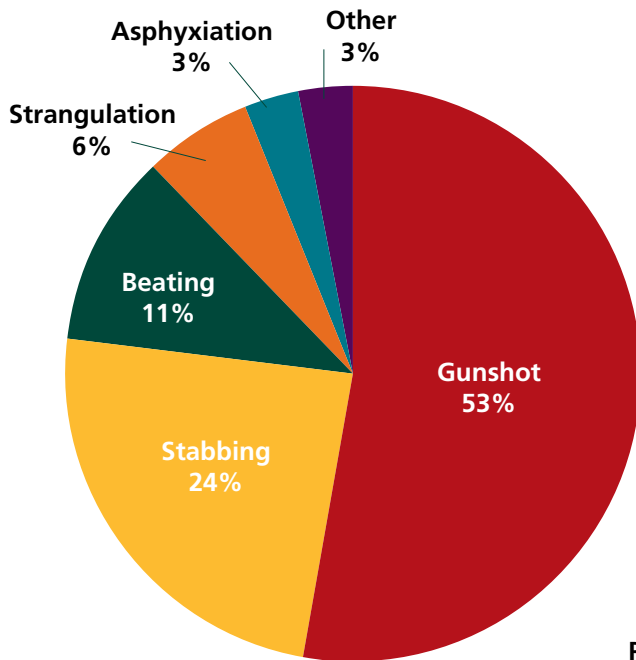
<sup>15</sup> Percentage based on known arrests or convictions, and does not refer only to incidents involving the decedent, but any prior history.



## Incident Characteristics

- 56% of perpetrators (36 of 64) committed suicide and an additional 3% (2 of 64) attempted to commit suicide.
- At the time of the incident, 17% (11 of 64) of perpetrators had previously or were currently using alcohol, 16% (10 of 64) had previously or were currently using drugs, and 2% (1 of 64) had previously or were currently using both. This information was based on self-reports by the perpetrator and/or medical toxicology reports.
- 16% of incidents (10 of 64) had a collateral victim (i.e., a victim other than the decedent; does not include perpetrator suicides).
- There were known child witnesses in 13% (8 of 62) of the cases.

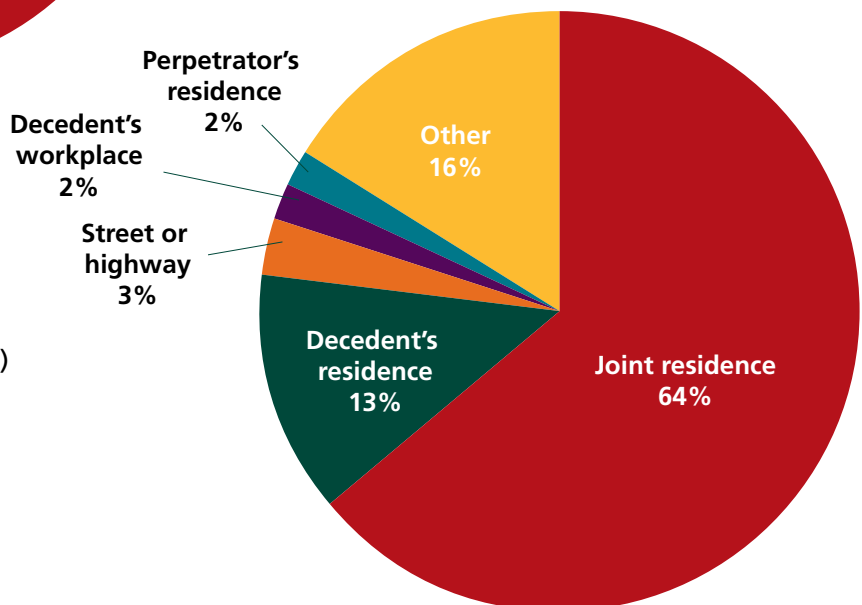
### MANNER OF DEATH (INCLUDES ATTEMPTED)



#### Manner of death (includes attempted):

- 53% gunshot (34 of 64)
- 24% stabbing (15 of 64)
- 11% beating (7 of 64)
- 6% strangulation (4 of 64)
- 3% asphyxiation (2 of 64)
- 3% other (2 of 64)

### PLACE OF INCIDENT

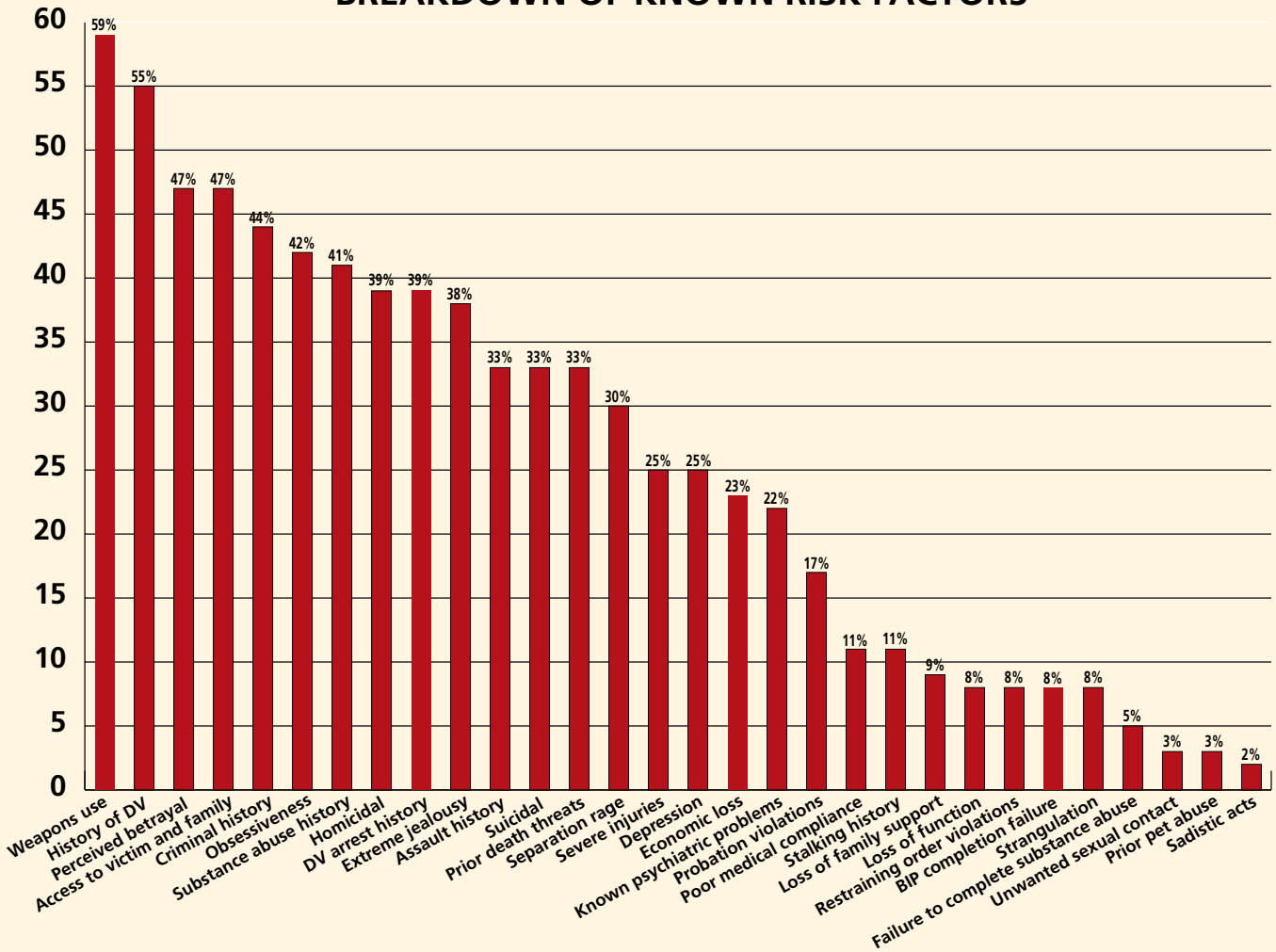


#### Place of incident:

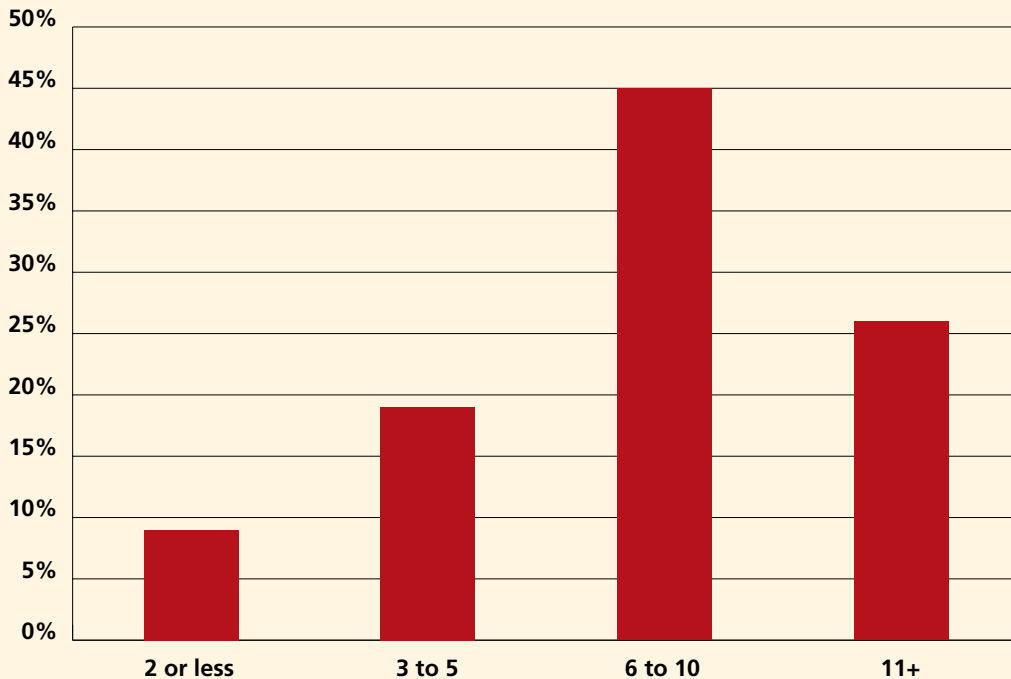
- 64% joint residence (41 of 63)
- 13% decedent's residence (8 of 63)
- 3% street or highway (2 of 63)
- 2% decedent's workplace (1 of 63)
- 2% perpetrator's residence (1 of 63)
- 16% other (10 of 63)

# LETHALITY FACTORS

## BREAKDOWN OF KNOWN RISK FACTORS



## PERCENT OF CASES BY TOTAL KNOWN RISK FACTORS PRESENT



## NOTABLE COMPARISONS

- Incidents reviewed last year had similar proportions of male to female decedents and perpetrators and were largely similar on average ages. There are, however, stark differences between these cases and those reviewed last year on racial breakdowns. For example, this year, a much smaller proportion of perpetrators and decedents were Hispanic (16% this year vs. 26% last year and 17% this year vs. 26% last year, respectively), and there were far more White perpetrators and decedents (48% this year vs. 35% last year and 55% this year vs. 40% last year, respectively).
- Couples included in this year's cases had slightly longer relationships: 11.86 years this year, on average, compared to 8 years last year.
- The cases this year had a notably higher percentage of couples who, at the time of the incident, were living together (66% this year vs. 56% last year).
- The percent of cases where family and friends reported knowing about prior domestic violence by the perpetrator was substantially higher this year than for the cases last year (56% this year vs. 37% last year).
- A substantially higher percentage of cases this year had evidence of a "do not contact" order against the perpetrator (28% this year vs. 9% last year). Similarly, there was a higher percentage of cases where, for perpetrators with a history of domestic violence, there was known participation in BIP (21% this year vs. 5% last year).
- Perpetrators committed suicide in twice as many of the incidents this year (56%) than last year (23%).
- Manner-of-death breakdowns were substantively identical this year to the breakdown of cases from last year's report (e.g., gunshot, stabbing, beating, strangulation, other).
- More consistent information was collected for a number of categories that have now been included in this year's report. For example, the mean length of separation time (in years) and perpetrator and decedent employment information.





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Staff support provided by the Florida Coalition Against Domestic Violence

*\*Chief Nolan McLeod passed away on June 20, 2012. Chief McLeod was an active member of the statewide team and worked tirelessly to end domestic violence. His dedication and commitment led to innovative programs designed to keep domestic violence survivors and their children safe and hold their batterers accountable. He will be greatly missed.*

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

**Alachua  
Brevard  
Broward  
Collier  
Duval  
Highlands  
Hillsborough  
Indian River  
Lee  
Leon  
Manatee  
Martin  
Miami-Dade  
Okeechobee  
Orange  
Palm Beach  
Pasco  
Pinellas  
Sarasota  
Seminole  
St. Lucie**

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