FINDINGS AND RECOMMENDATIONS FROM THE GEORGIA DOMESTIC VIOLENCE FATALITY REVIEW PROJECT

GEORGIA COALITION AGAINST DOMESTIC VIOLENCE

DECEMBER 2004
GEORGIA COALITION AGAINST DOMESTIC VIOLENCE
GEORGIA COMMISSION ON FAMILY VIOLENCE

This first report of the Georgia Fatality Review Project is dedicated to the victims of domestic violence who lost their lives to homicide and their family members, friends and surviving children who must go on without their loved ones.

It is out of the deepest respect for the value of the lives lost and the challenges for those left behind that we endeavored this first year in an attempt to find ways to prevent future loss of life and the unimaginable pain suffered by homicide survivors.

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Foreword

Why Fatality Review? Some might feel with victim advocacy dollars dwindling, that every possible resource should go to victim services. But those who have been working to end domestic violence for many years, advocates, police officers, prosecutors, and others will tell you – domestic violence homicide is just not declining as significantly as many had hoped. For reasons that this project seeks to uncover, some cases move through the community undetected and proceed to lethality, while others escalate to homicide right under our nose, in families who made many calls for help.

The Georgia Fatality Review Project is focused on systems change. The project is focused on empowering communities with tools and processes that will help them uncover ways to improve their response to increase batterer accountability and victim safety. This project is not about finger pointing. It is based on the assumption that most interveners are doing the best they can, with what they know and the tools they have. The Fatality Review Project makes its goal to identify gaps in systems and in collaboration to give interveners more knowledge and better tools, through the arduous process of examining cases that have resulted in death.

The challenges to effective intervention in family violence cases are universal. They have to do with resources, knowledge, training, information and how it is or isn't shared, policies, protocols, forms, and collaboration. You notice we didn't say people. The premise of this project is that any individual in any system may make mistakes, but the way to prevent those mistakes in the future has to do with looking at how that individual was prepared for the job. The Fatality Review Project remained true to this principal – that the challenges are universal and that the solutions are system, not individual, based. And from this starting point, the 13 participating communities came to some remarkable findings and were able to make meaningful and practical recommendations for community improvements.

Our state owes a debt of gratitude for the valuable lessons learned in this first year to the first 13 brave communities who stepped forward. Not everyone relished the idea of reviewing a case where someone had died on their watch. No one looked forward to the day their policies were discussed or their agency's response was assessed. But this brave self-examination, this willingness to not take it personally, but to take the risk to admit there might be a better way next time – all resulted in some real learning about how to respond to the victim who is battered today. We saw each community come closer together, grow, have franker dialogues and make many important discoveries that will ultimately help in building a coordinated community response.

Finally, we all owe a debt of gratitude to the family and friends of the deceased in the reviewed cases, who took time to go back to this painful period in their lives, to share what they knew. They brought a dimension to the review process that could not have come from anywhere else, and helped us all come to better understand the many steps their loved ones took to try to end the violence in their lives. In doing so, they helped us better know how to respond to the thousands of families in Georgia still living with the preventable tragedy of domestic violence.

The purpose of Fatality Review is to improve coordinated community response. Here's what the Webster dictionary has to say about what the words "Coordinated," "Community," and "Response" mean.

Coordinated

Function: verb
1 : to put in the same order or rank
2 : to bring into a common action, movement, or condition : HARMONIZE
3 : to attach so as to form a coordination complex

OPHELIA HOWARD, AGE 39, WAS SHOT BY HER HUSBAND IN HER SISTERS HOME. HER SISTER SURVIVED TWO SHOTS TO HER HEAD AND ONE THROUGH HER CHEST.

Community

Function: noun
Usage: often attributive
1 : a unified body of individuals: as a : STATE, COMMONWEALTH b : the people with common interests living in a particular area; broadly : the area itself c : an interacting population of various kinds of individuals in a common location d : a group of people with a common characteristic or interest living together within a larger society e : a group linked by a common policy

Response

Function: noun
1 : an act of responding
2 : something constituting a reply or a reaction: as a : a verse, phrase, or word sung or said by the people or choir after or in reply to the officiant in a liturgical service b : the activity or inhibition of previous activity of an organism or any of its parts resulting from stimulation
c : the output of a transducer or detecting device resulting from a given input

ACKNOWLEDGEMENTS

The Georgia Commission on Family Violence (GCFV) and the Georgia Coalition Against Domestic Violence (GCADV) owe a great amount of gratitude to the many individuals and systems that made Georgia's Fatality Review Project possible. With strong Task Forces, high participation from a variety of systems, and clear direction from the project coordinators this first year has been a success.

Fatality Review Project Staff

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Nancy Grigsby, Executive Director, Georgia Coalition Against Domestic Violence

The Georgia Coalition Against Domestic Violence is a state coalition of about 70 organizations responding to domestic violence in Georgia. GCADV operates Georgia's 24 hour toll free domestic violence hotline (800-334-HAVEN) and provides education, consultation, training, technical assistance, and dissemination of research and information. GCADV also promotes best practices and resources for victims and their children through a number of initiatives including the Fatality Review Project, a transitional housing project, a rural child abuse and domestic violence project and a legal assistance project. Finally, GCADV advocates for improvements in systems responding to victims and offenders through public policy and legislative advocacy.

The Georgia Commission on Family Violence is a Commission under the Governor's Office, administratively attached to the Department of Corrections. The Commission was legislatively formed to assist in the development of task forces in judicial circuits and to monitor legislation impacting families experiencing domestic violence. GCFV is the certifying body for Family Violence Intervention Programs in Georgia and provides training, technical assistance to FVIPs and task forces, and hosts an annual state-wide conference on domestic violence.

Special Thanks

Shelley Senterfitt, Attorney at Law provided legal research and counsel for the project.
Dr. Mary Finn from Georgia State University provided assistance with data.
Karly Taylor and Rhiannon Morgan devoted their time as Georgia State University Criminal Justice student interns to attend reviews, document the process and provided assistance with data.
Judge Mike Brigner provided technical assistance and training at the first Fatality Review conference in Georgia.
Michelle Abato volunteered her time on the project to attend reviews and assist with documentation.
Astrid Lyons volunteered her time to provide skillful and artistic design work for the final report.

Our special appreciation goes to **Margaret Hobart and the Washington State Coalition Against Domestic Violence** for the guidance and technical assistance provided in our first year completing Fatality Reviews in Georgia. Our efforts benefited greatly from the ground-breaking work done by Washington review teams, under the leadership of Margaret and the coalition staff.

Financial Support

The Georgia Fatality Review Project was funded by the **Criminal Justice Coordinating Council** through **Violence Against Women Act** funds. We are grateful for the grant which allowed our state to join many others around the country in beginning fatality reviews. The project has been funded for a second year, through 2005.

Fatality Review Project Advisory Committee

Thanks to our Fatality Review Project Advisory Committee whose leadership and time dedication helped to provide direction for this project. The members of the Advisory Committee include:

Mr. Michael Nail
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Mr. Derek Marchman
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Mr. Bill L. Garrett
Humane Society
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Review Teams

We acknowledge the big commitment from the 13 review teams around the state who took the risk and the time to participate in this first year of Fatality Reviews in Georgia. The following communities, organizations and individuals ultimately made Fatality Review a reality in Georgia and broke ground for this work to continue in other areas of the state.

Appalachian Judicial Circuit
Sara Grainger, District Attorney's Office Appalachian District
Carla Poole, District Attorney's Office Appalachian Judicial Circuit
Chief Callohan, Ellijay Police Department
B.D. Jones, McCayville Police Department
Cami Fowler, Law Clerk for Judge Weaver
Sherri Kirk, Gilmer County Victim Witness
Julia Lasley, Pre-Trial Probation Program
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Cindy Westberg, North Georgia Mountain Crisis Network
Chief Arp, East Ellijay Police Department
Chief Harold Cantrell, Jasper Police Department
Chief Dub Bryant, Nelson Police Department

Atlanta Judicial Circuit
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Edwina Knox-Betty, Partnership Against Domestic Violence
Adair Connor, Partnership Against Domestic Violence
Georgee Corley, Fulton County Solicitor's Office
Al Dixon, Fulton County District Attorney's Office
Marcus Flowers, Men Stopping Violence
Judge Richard Hicks, Magistrate Court, Fulton County
Tamara Hurst, Alternative Sentencing and Mitigation Institute
Sergeant Liane Lacoss, Atlanta Police Department Homicide Unit
Scott Long, Fulton County District Attorney's Office
Sharon Stearns, Fulton County Solicitor's Office
Lizz Toledo, Alternative Sentencing and Mitigation Institute
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Detective Sergeant Danny Greeson, Woodstock Police Department
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Ashley Long, Cherokee Center for Change, Inc.
Meg Rogers, Cherokee Family Violence Center
Michael Messina-Yauchzy, Reinhardt College

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Sgt. Tina Daniel, Clayton County Sheriff's Department
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Elizabeth Toledo, Angels Recovery (FVIP)
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Dion Hurley, Savannah Police Department
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Richard Wazeter, ACS of Ft. Stewart, Ga.
Yukeyveaya Wright, Chatham County Victim Witness

Griffin Judicial Circuit
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Detective Debbie Chambers, Fayetteville Police Department
Philip Cherry, Fayetteville State Probation
Dan Hiatt, District Attorney's Office
Michelle Ivey, District Attorney's Office
Linda Jeffries, Spalding County Sheriff's Office
Vanessa Motley, Promise Place
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Cindy Polo, Promise Place
Sonja Strickland, Promise Place

Houston Judicial Circuit
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Julia Carter, Salvation Army Safehouse
Natisha Germany, Salvation Army Safehouse
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Charlene Giles, Houston County Sheriff's Office
Tina Greenlee, Mentor Network
Veronica Griffin, Robins Air Force Base
Robert Gurd, Houston County DA's Office

Mountain Judicial Circuit
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Scott Chitwood, Clarkesville Probation
Suzanne Dow, Circle of Hope
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Kris Jones, Georgia Legal Services
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Sharon Moore, District Attorney's Office
Tina Morris, DFCS
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Alice T. Wood, Wiley Presbyterian Church
Beverly Woodward, FAITH

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Office Ojilvia Zavala, Floyd County Police Department

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Ladonna Varner, Probation

Tifton Judicial Circuit
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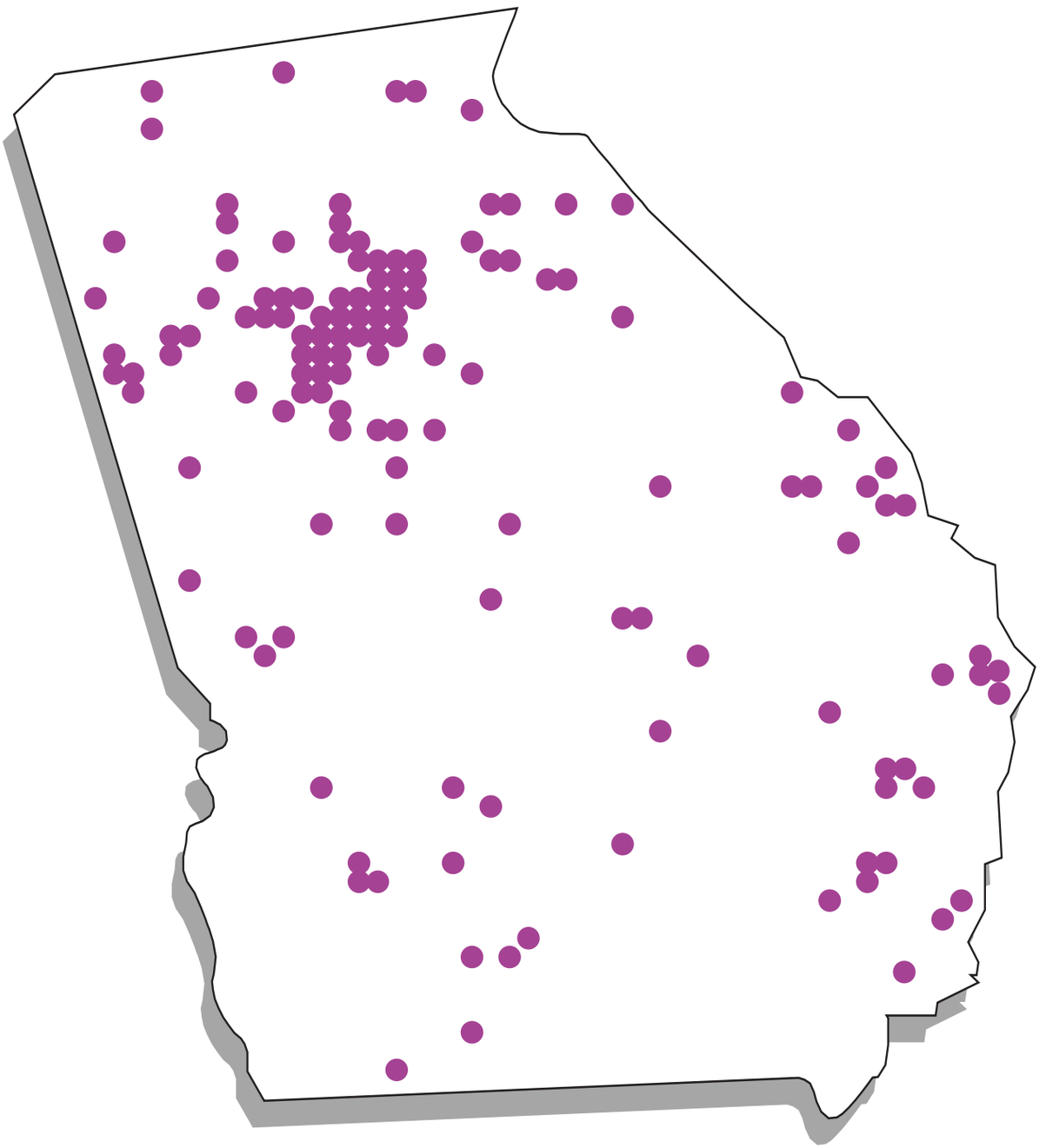
Mary Meeler, District Attorney's Office
Judge Larry Mims, State Court
Captain Tony Strenth, Sylvester Police Department
Kim Vickers, Irwin County Family Connection

2003 Domestic Violence Deaths in Georgia



ONE HUNDRED AND THIRTY-SEVEN DEATHS WERE THE RESULT OF DOMESTIC VIOLENCE

2003 Domestic Violence Deaths in Georgia

County	# of Primary Victims	# of Secondary Victims	# of Alleged Perpetrators	Total Deaths per County	Means of Death
Barrow	1		1	.Gunshot	
Bartow	2	1	1	4	.2 Gunshots, 2 Unknown
Ben Hill	1		1	.Asphyxiation	
Bibb	1		1	.Gunshot	
Burke	2		2	.Gunshot, Stabbed	
Butts	1		1	.Arson	
Calhoun	2	1	3	.3 Gunshots	
Camden	1		1	.Gunshot	
Carroll		1	1	.Gunshot	
Chatham	5	1	6	.6 Gunshots	
Cherokee	1		1	.Gunshot	
Clarke	3		3	.1 Stabbed/Beaten, 2 Gunshots	
Clayton	1		2	3	.3 Gunshots
Cobb	5		1	6	.2 Strangled 4 Gunshots
Colquitt	2	1	3	.2 Gunshots, 1 Stabbing	
Columbia			1	.Gunshot	
Crisp	2		2	.Gunshot, Strangulation	
Dekalb	10	3	4	17	.16 Gunshots, 1 Stabbing
Dougherty	1		1	.Stabbing	
Douglas		1	1	.Beaten	
Elbert	1		1	.Beaten	
Fannin	1		1	.Strangulation	
Floyd	1		1	.Burned to death	
Forsyth	2		2	4	.4 Gunshots
Fulton	6		4	10	.5 gunshots, 3 stabbing, 1 beaten with brick, 1 unknown
Glynn	1		1	2	.2 Gunshots
Grady	1		1	.Stabbing	
Gwinnett	6		6	.1 pushed from car, 2 Gunshots, 1 Strangulation, 1 Unknown, 1Beaten	
Habersham	1		1	.Gunshot	
Haralson	1	2	1	4	.4 Gunshots
Henry	2	1	1	3	.4 Gunshots
Houston	1		1	.Gunshot	
Jefferson	1		1	2	.2 Gunshots
Laurens	1		1	2	.2 Gunshots
Liberty	2	1	1	4	.1 Strangulation, 3 Gunshots
Madison			2	2	.1 Hung himself, 1 Gunshot
McDuffie			1	1	.Gunshot
Montgomery	1		1	.Gunshot	
Muscogee	1	1	1	3	.2 Gunshots, 1 Stabbing
Newton	1		2	3	.2 Gunshots, 1 Stabbing
Oglethorpe	1		1	.Stabbing	
Paulding	1		1	.Gunshot	
Polk			1	1	.Gunshot
Richmond	3	1	4	.1 Beaten, 1 Strangulation, 2 Gunshots	
Tattnall			1	1	.Gunshot
Troup	1		1	.Gunshot	
Upson		1	1	2	.1 Stabbing, 1 head injury
Washington			1	1	.Stabbing
Wayne	2		2	4	.3 Gunshots, 1 Stabbing
Webster			1	1	.Gunshot
Wheeler			1	1	.Gunshot
White	1		1	2	.2 Gunshots
Whitfield	1	1		2	.2 Gunshots
Undisclosed	2			3	.3 Gunshots
TOTAL:	**81**	**18**	**38**	**137**	

101 Gunshots, 15 Stabbings, 1 head injury 7 Strangulations, 5 Beatings, 1 hanging, 1 pushed from the car, 2 arson, 3 unknown, 1 Asphyxiation

Executive Summary

Overview

As in the rest of the country, Georgia has seen a decrease in the overall crime rate but not a significant reduction in the rate at which women are being murdered at the hands of their intimate partners (NIJ, 2002). The Violence Policy Center (VPC) ranked Georgia 17th in the country in its rate of men killing women, in homicides where one no one else was killed (called single victim, single perpetrator cases). VPC includes victims who were the wife, common law wife, ex-wife or girlfriend of the perpetrator. VPC identified 76 such deaths in 1998 (ranked 15th), 87 such deaths in Georgia in 2001 (ranked 9th) and 70 such deaths in 2002 (ranked 16th).

The following breakdown of 2003 domestic violence related deaths is provided by the Georgia Coalition Against Domestic Violence from its clipping service and from reporting domestic violence programs; this count represents all the homicides known to us at the time of this report:

Of the Intimate Partner Domestic Violence Victims Killed:
- 71 were heterosexual women
- 6 were heterosexual men
- 3 were gay men
- 1 was a lesbian woman

MARLENE HUGGINS, AGE 37, WAS SHOT TO DEATH BY HER HUSBAND. HE THEN SHOT AND KILLED THEIR 13 YEAR-OLD DAUGHTER, AND THEN HIMSELF.

Of the other Family and Friends Victims Killed:
- 11 were children
- 2 were family members
- 5 were other persons

Of the Alleged Domestic Violence Perpetrators who Died:
- 2 were killed by law enforcement officers
- 25 committed suicide after murdering or attempting to murder the victims
- 8 were killed by victims
- 3 were killed by children

Furthermore, while homicides do not appear to be declining significantly in this state, calls to law enforcement have (GBI). This fact begs the question, why are fewer victims of domestic violence calling the police? Do they feel safe reporting this crime? Do they perceive that it is more dangerous to ask for help? How does the system response in Georgia protect victims while holding offenders accountable? And what can we do to make it better?

The state of Georgia has great geographical diversity ranging from rural areas to one of the most populous cities in the nation. With 49 Judicial Circuits, 159 counties, over 600 law enforcement jurisdictions, and several court systems, Georgia has vast opportunities to analyze systems' response and promote change that will ensure that all systems are working from the same page.

Local communities understand this better than outsiders looking in. They know that while there are different challenges and barriers to system response, there are also unique accommodations and strengths specific to different communities. Local domestic violence task forces throughout the state have found that building upon these positive attributes can increase their community's coordinated response—and in some places these task forces have been working on this objective successfully for years. Fatality Review Teams are yet another tool for task forces to continue with this important work. In fact, communities across the country have found that Fatality Review Teams provide necessary change agents such as law enforcement, prosecutors, courts, and medical response representatives with the information they need to respond more strongly, consistently, and efficiently (Washington State Fatality Review Project, 2001). Georgia has looked to its task forces, locally and independently led by that community's experts, to begin the Fatality Review process.

Mission Statement

The Georgia Fatality Review Project seeks to enhance the safety of victims and accountability of batterers by conducting detailed reviews of fatalities and by preparing, publishing, and disseminating objective information gained from these reviews as a tool for identifying gaps in system response, improving statewide data collection, enhancing efforts to train systems on better responses, identifying critical points for intervention and prevention, and for providing a forum for increasing communication and collaboration among those involved in a coordinated community response to domestic violence.

Process

Funded federally by the Violence Against Women Act (VAWA) and through Georgia's Criminal Justice Coordinating Council, the Georgia Coalition Against Domestic Violence (GCADV) and the Georgia Commission on Family Violence (GCFV) joined together and each hired a Fatality Review Project Coordinator. Helping to direct the project under a national technical assistance grant from the Department of Justice, was the Washington State Coalition Against Domestic Violence. We identified leaders in each system across the state to create an Advisory Committee that routinely met to provide knowledge, networking abilities, support, and direction. GCADV and GCFV identified 13 Task Forces across the state, rural and urban, based on system representation and otherwise strength of the Task Force to begin the project. More detailed information is provided in the methodology section of this report.

General Findings

Choosing the domestic violence fatalities was a different process for each of the communities. While the teams tried to pick homicides that were most current, it was important to choose cases where criminal prosecution was completed (or ruled out by suicide of the suspect) and no further appeals were pending on the case. The oldest case reviewed was from 1996 and the most recent occurred in the year 2004. Many communities chose to review cases that had received a lot of media attention. While some smaller communities had fewer cases to choose from, some larger communities chose diverse cases to get a bigger picture of the variety of possibilities of system involvement. Interviews with surviving family and friends were conducted in several of the cases.

Of the 25 cases reviewed there were a total of 34 fatalities. This includes:

- 24 intimate partner victims
- 7 alleged perpetrators
- 1 sister of the intimate partner victim
- 1 aunt of the intimate partner victim
- 1 child of the intimate partner victim

There were also 3 unsuccessful murder attempts on:

- 1 intimate partner victim
- 1 sister of the victim
- 1 mother of the victim

While more specific data related to the Fatality Review Project's findings can be found further into this report, the following summarizes basic findings.

Means of death of the victims

- 12 cases involved death by firearm
- 6 cases involved death by stabbing with a sharp object
- Strangulation was the cause of death for 5 victims.
- 2 fatalities were caused by bludgeoning/other traumatic injuries

CHERYL GREAR ROBERTSON, AGE 38, WAS SHOT TO DEATH BY HER LIVE-IN PARTNER, WHO THEN COMMITTED SUICIDE.

Significant Findings

- 68% of the intimate partner victims and 60% of the perpetrators were employed outside the home.
- In over 80% of the cases, the perpetrator was documented as having committed an act of domestic violence before.
- In just over 70% of the cases, the perpetrator had a violent criminal history with the court.
- In nearly 60% of the cases, the perpetrator was known to have previously threatened to kill the domestic violence victim.
- In over 50% of the cases, the victim was known to have been threatened by the perpetrator with a firearm or another weapon.
- Of all the sources of information and public records, the family and friends of the victim had the most comprehensive knowledge of the history of abuse.
- In 43% of the cases, the victim did not have injuries during prior calls the police, indicating the assessment of risk for lethality cannot rest solely on the level of prior injury to the victim.
- Over 40% of perpetrators were known to have made threats to commit suicide prior to the homicide; in reviewed cases, 28% committed suicide after the homicide and 4% attempted suicide at the homicide.

Each of these findings is extremely significant. For instance, knowing that significant numbers of perpetrators had been violent before raises awareness about the need to respond swiftly and definitely the first time an incident occurs. Furthermore, gleaning that the family and friends had the most comprehensive knowledge of the victims' situations points to the importance of developing strategies to involve everyday citizens in domestic violence intervention and homicide prevention. Friends, co-workers and family members who are not part of a responding system to family violence cases have been largely overlooked as a resource for intervention. The findings in these cases indicate they are a rich potential resource for increasing victim safety and offender accountability, if they can be empowered, informed and mobilized to action.

Similarly, a significant number of victims and perpetrators were employed outside the home, indicating another potential entity which could play a role in homicide prevention: employers. Many review teams identified employers as potential partners in task force and made recommendations regarding the unique and powerful role employers can play in responding to domestic violence.

The finding that the majority of the selected homicides were committed with firearms is significant. Federal legislation in the last decade has been enacted to reduce gun access for domestic violence perpetrators. While homicide can clearly be committed without guns, the intersection of gun access with significant events, such as a divorce just finalized, raises the question: what if the offender did not possess such a lethal weapon at the time of such an intense event in his life? Would the absence of a gun only postpone, or eliminate, that death? In a study in Atlanta of domestic violence, firearm associated domestic assaults were 12 times more likely to result in death than non-firearm associated assaults between family and intimates. (VPC, Salzman et al, JAMA, 1992). And an Archives of Internal Medicine study found that when there were one or more guns in a home, the risk of homicide increased more than three times (VPC, Bailey, et al, 1997).

The findings around suicide are significant: over 40% of perpetrators were known to have made threats to commit suicide prior to the homicide and in reviewed cases 28% committed suicide after the homicide and 4% attempted suicide at the homicide. Considering that we are only reporting known suicidal ideation prior to homicides, this behavior is significant, especially when combined with the number of perpetrators who actually attempted and completed suicide. These findings coincide with the work of Dr. Jacqueline Campbell, whose groundbreaking research in risks for domestic violence homicide highlights depression and suicide, among other risk and protective factors (Campbell, 2003).

All of the findings, and those to follow in this report came about through the commitment and perseverance of dedicated individuals across the state who continually strive to end domestic violence. While the fatalities reviewed in the first year of the project account for just a snapshot of an endless variance of circumstances that victims of domestic violence endure and challenge, many findings were nearly identical to those found across the state. Fatality Reviews are a new tool—both intimidating and enlightening—for task forces to use to garner insight, awareness, and momentum in ending domestic violence. The work these task forces have done, on a volunteer basis, has just begun. Taking the finding and recommendations and implementing them in the coordinated community response will be the next step in ensuring victim safety and offender accountability throughout Georgia.

METHODOLOGY

Task Forces Form Committees

The domestic violence task force in each participating community was asked to form a multi-disciplinary Fatality Review Committee (Review Team) to function as a subcommittee of the task force. The systems to be invited were:

Domestic violence shelters
Probation officers
Law enforcement
DFCS
Medical professionals
School counselors
Advocates (rape crisis center, court advocates)
District Attorneys & Solicitor Generals
Judges
Family Violence Intervention Programs
Drug and Alcohol counselors
Clergy

Each Fatality Review Committee sent 7-10 representatives to a one day Fatality Review Training.

Cases Selected

After identifying and training the 13 Review Teams, the two coordinators began to work with each one to identify from one to three local domestic violence homicides to review. Homicides were defined as domestic violence related if the victim and perpetrator were current or former intimate partners. Cases involving the homicide of a secondary victim such as a friend, current partner, child or family member of the domestic violence victim were also considered domestic violence related. Fatality review committees chose their own process for selecting cases to be reviewed with three criteria in mind. All civil and criminal proceedings related to the victim and the perpetrator had been closed with no pending appeals. The perpetrator had been identified by the criminal justice system. When possible, the date of the homicide did not extend beyond 3-5 years. In communities with fewer cases to select from, it was sometimes necessary to review cases outside of this timeframe. Fatality review committees also selected cases that they believe had a significant impact on their community.

Case Information Collected

Once the cases were selected, the committee members gathered public records pertaining to the case. The majority of the information was located in the prosecutor's file and/or the homicide file. Only information that could be obtained pursuant to the Open Records Act was collected.

Family & Friend Interviews

When appropriate, the Fatality Review Project Coordinators sought out interviews with surviving family and friends of the victim, who in turn provided incredible insight not gleaned from the public documents. The surviving family and friends of the domestic violence homicide victim were given an opportunity to share information with the fatality review committee. This process was facilitated by the Project Coordinator who identified them through information in the existing public documents. A letter was mailed explaining the fatality review process and the purpose of the project. Family members and friends were invited to contribute information via a telephone interview, an in person interview, or written communication. They were also given the option to decline participation at which time their request was respected.

Most family members and friends who participated in interviews did so by phone, although a few chose to meet coordinators in person. Most discussions exceeded an hour and were incredibly emotionally draining for the surviving family members, and the interviewers. The discussions were open ended, with family members and friends being invited to share what they wanted the review team to know about their loved one, the steps she took to try to be safe and what they wanted others to know about her perceptions of her options in that community. For more detail about these interviews, see the Findings and Recommendations section on Surviving Family and Friends.

Case Chronology Developed

The Chairperson of the Fatality Review Team then handed all the documents over to the Project Coordinator so that a chronology of all events leading up to the fatality could be developed. The chronology was developed with a focus on all prior significant events leading up to the death. These included prior acts of violence perpetrated by the person who committed the homicide, whether against the reviewed victim or another. The focus of the chronology was to identify every opportunity any segment of the community had to intervene in the escalation of violence. The completed chronology was distributed to review participants prior to the review. Review participants read the chronology to become familiar with the case and organize their thoughts prior to the review.

Death Reviews

The Fatality Review Team meetings lasted on average 3-4 hours in length. Together, after signing a confidentiality statement, observing a moment of silence for the victim(s), doing an out-loud reading of the chronology, the teams went item by item through the chronology looking to where the community could have stepped in – and how could the system response have been stronger. With a trust in each other and a commitment to not blame one another, the Fatality Review Teams—with a critical eye—identified gaps in local response, areas where practice didn't follow protocol, and innovative ideas to make the system response more effective in increasing victim safety.

Development and Implementation of Findings and Recommendations

Review teams then made findings about the factors in each case which appeared to contribute to the death, or conversely, actions, if taken, which might have prevented the death. Review teams were always focused on a systems review – what was available in that system for victims and offenders, what was the protocol for response, was it followed or not, and what monitoring, training, support and accountability existed in that system for workers who responded to families. From the findings, each team made recommendations about changes to systems that would improve victim safety and offender accountability. For a summary of findings and recommendations by system, please see the Findings and Recommendation section of this report.

Data Analysis

Following the meeting, the Project Coordinators filled in a data tool designed by GCADV and GCFV in collaboration with Georgia State University's (GSU) Criminal Justice Department with all identifying factors of the location and the victim removed. The 40 page completed data tool was then turned over to GSU to be put into a database to form the aggregate data that comprises the Data Findings section of this report.

MARISSA J. VAZIRI, AGE 27,
WAS STRANGLED TO DEATH IN HER HOME BY HER
BOYFRIEND OF SIX WEEKS.

DATA FINDINGS

The following data, while stripped of any identifying information as to what fatality or county it came from, was directly collected from the fatality reviews. Data from some reviews is partial, so some tables will reflect 25 cases, while others will reflect less, indicating that all data was not available on that factor. Where this occurred, the section will note that the data describes the cases where this data set was known, but it may not be descriptive of all the cases reviewed.

Data from the fatality is organized into the following sections:
Section 1: Demographics of the Victims and the Perpetrators
Section 2: Domestic Violence Fatality Data
Section 3: Domestic Violence Perpetrator's History of Abuse and Other Lethality Indicators
Section 4: Civil & Criminal History: Law Enforcement, Prosecution, and Sanctions
Section 5: Agencies Involved in the 5 Years Prior to the Homicide

Section 1: Demographic Information

Demographic Information on Victim and Perpetrator

	Victim		Perpetrator	
Characteristic	**Number**	%	**Number**	%
Gender				
Female	25	100	0	0
Male	0	0	25	100
Age (Mean)	**36.08**		**39.42**	
Education Level				
Less than 8th	0	0	1	4.0
9th-11th	2	8.0	1	4.0
High school/GED	7	28.0	6	24.0
Trucking school	0	0	1	4.0
Some college	3	12.0	3	12.0
Associate degree	1	4.0	0	0
Bachelor's degree	4	16.0	0	0
Unknown	8	32.0	13	52.0
Employment Status				
Employed full time outside of home	12	48	13	52.0
Employed full time (self employed)	1	4.0	2	8.0
Employed part time outside of home	4	16.0	2	8.0
Employed part time (self employed)	0	0	1	4.0
Employed part time and student	1	4.0	0	0
Unemployed (student)	1	4.0	0	0
Unemployed (homemaker)	4	16.0	0	0
Unemployed	0	0	2	8.0
Retired	2	8.0	1	4.0
Disabled	0	0	1	4.0
Unknown	0	0	3	12.0
Sources of Financial Support				
No income	1	4.0	2	8.0
Personal wages	16	64.0	19	76.0
Personal wages and family support	2	8.0	0	0
Personal wages and alimony	1	4.0	0	0
Personal wages & DV perpetrator	1	4.0	0	0
Food stamps, family support & WIC	1	4.0	0	0
DV Perpetrator	1	4.0	0	0
Drug dealing	0	0	1	4.0
Retirement pension	0	0	1	4.0
Disability	0	0	1	4.0
Widow's pay	1	4.0	0	0
Unknown	1	4.0	1	4.0
Citizenship/Immigration Status				
Citizen of US	24	96.0	24	96.0
Green Card	1	4.0	1	4.0
Primary Language				
English	24	96.0	23	92.0
Russian	1	4.0	1	4.0
Spanish	0	0	1	4.0

Percentages may not total to 100 due to rounding.

Section 2: Domestic Violence Fatality Data

Who Was Killed

Of the 25 cases reviewed there were a total of 34 fatalities. This includes:

- 24 intimate partner victims
- 7 alleged perpetrators
- 1 sister of the intimate partner victim
- 1 aunt of the intimate partner victim
- 1 child of the intimate partner victim

There were also 3 unsuccessful murder attempts on:

- 1 intimate partner victim
- 1 sister of the victim
- 1 mother of the victim

Two of the intimate partner victims were pregnant at the time of their deaths.

Location of Homicides

Most homicides occurred in the home. The following table describes where the reviewed fatalities occurred.

Home	Motor Vehicle	Public Building	Sidewalk/ Parking Lot	Hotel Alley	Country Road	Neighbor's Porch	Vacation Rental
17	2	1	1	1	1	1	1

Most of the reviewed homicides occurred in a home (17 or 68.0%): the deceased's home in eleven cases (44.0%); the home of deceased's family or friends in three cases (12.0%); the home of the person who caused the death in two cases (8.0%); or the home shared by the deceased and the person who caused the death in one case (4.0%). The remaining deaths occurred in the following locations: motor vehicle (2 or 8.0%), public building (1 or 4.0%), street/parking lot/sidewalk (1 or 4.0%), hotel alleyway (1 case or 4.0%), country road (1 or 4.0%), neighbor's porch (1 or 4.0%), and vacation rental (1 or 4.0%). In only two cases did death occur in a different place from where injuries were received, and in both cases the deaths occurred in, or in route to, a hospital.

JAMITRA ECTOR DAVIS, AGE 30, WAS SHOT TO DEATH IN HER CAR WHILE ATTEMPTING TO DRIVE AWAY, BY HER HUSBAND. HE ALSO SHOT HER MOTHER, WHO SURVIVED, BEFORE HE COMMITTED SUICIDE AT THE SCENE.

Homicide Narratives

The following table briefly describes each homicide reviewed. Sentencing data sources are Prosecutor's files, Georgia Department of Corrections, and Fatality Review Teams. This data represents our best efforts to reflect accurate sentences, although some public records varied.

Brief Narratives of Each Fatality	Sentence Imposed for this Homicide
Case 1: DV perpetrator stabbed domestic violence victim in car and then fatally stabbed himself, while their children retrieved clothing from the home. The children returned to the car and discovered the bodies of their parents.	Deceased perpetrator.
Case 2: DV perpetrator shot the domestic violence victim in the head while she was sitting on the bed, as her infant grandson slept on the bed next to her.	Pled to Voluntary Manslaughter. Maximum possible release date is March 20th, 2022.
Case 3: DV perpetrator beat and strangled domestic violence victim to death. He drove to the airport and left her body in his truck and then fled to Texas. Perpetrator eluded authorities until after he was featured on America's Most Wanted program.	Sentenced to life in prison for Malice Murder plus 12 consecutive months for Simple Battery.
Case 4: DV perpetrator beat and suffocated domestic violence victim with unknown object, while he was still on probation for another crime.	Pled guilty to Voluntary Manslaughter. Sentenced to 14 years in prison.
Case 5: DV perpetrator beat domestic violence victim with fireplace poker and strangled her with a telephone cord around her neck, while her toddler son watched.	Pled guilty to Voluntary Manslaughter. Sentenced to 20 years in prison.
Case 6: DV perpetrator broke into house of the domestic violence victim's aunt and shot and killed domestic violence victim and her aunt, as her toddler laid next to her in bed. The perpetrator also shot 2 other family members in the home, who survived.	Found guilty of 2 counts of Murder, Aggravated Assault, and Burglary. Sentenced to two life terms plus 60 consecutive years.
Case 7: DV perpetrator shot the lock off the door of the domestic violence victim's mother's home, shot his daughter and wife with a shotgun killing them both, and then killed himself. The homicides occurred on Christmas morning, one day before the couple's divorce was to be final.	Deceased Perpetrator.
Case 8: DV perpetrator entered home of the domestic violence victim's sister and shot DV victim and her sister, within an hour after two police visits to the home. The sister survived.	Convicted of murder. Sentenced to life without parole.
Case 9: DV perpetrator fatally stabbed domestic violence victim over 100 times two months after he was arrested for beating her unconscious with a lamp.	Perpetrator was acquitted by reason of insanity. It was later determined that the perpetrator was neither safe to return to society or appropriate for treatment in a mental health facility.
Case 10: DV perpetrator fatally struck domestic violence victim in head several times and unsuccessfully attempted suicide. The perpetrator was close to finishing his court mandated FVIP class.	Sentenced to life with the possibility for parole.
Case 11: DV perpetrator stabbed domestic violence victim. She ran to neighbors and he pursued her. The DV victim's sister followed them and when she tried to go for help, the perpetrator chased DV victim's sister, and then stabbed her to death. The domestic violence victim survived. The day of the homicide the perpetrator had told his probation officer, "go ahead and put me in jail, I'm not going to that FVIP."	Convicted of murder. Sentenced to life plus 20 years with the possibility of parole.

Case 12: DV perpetrator had handcuffed domestic violence victim who tried to escape. DV perpetrator's friend was present and DV victim begged for help as the perpetrator caught her and carried her back inside. DV perpetrator then shot DV victim and then himself as his friend stood on the porch. (DV victim was found with handcuff on one wrist and the key in her right hand.) The perpetrator left a "To do" list, "Do away with (victim's name) and I."	Deceased perpetrator.
Case 13: DV perpetrator came to victim's job, took her in his car to another location where he threatened a friend of the victim with a gun, then drove her home where he hit the victim in the face, pulled out some of her hair, and then shot her in the back.	Sentenced to life in prison for murder.
Case 14: DV perpetrator stalked the domestic violence victim after their separation, then pressured her to go to a cabin for weekend to work things out. When she told him that she did not want to be with him, he strangled her to death.	Convicted of murder and sentenced to life with the possibility of parole.
Case 15: DV perpetrator shot domestic violence victim 3 times and then shot himself while their teen aged daughter was home at the time. At the time of the homicide, the perpetrator was attending anger management classes and had a TPO against him which specified he could live in the basement of the marital residence.	Deceased perpetrator.
Case 16: DV perpetrator shot domestic violence victim in her torso at close range with a 12-gauge shotgun. The victim's three adult daughters and three grandchildren were present at the homicide.	Pled to Voluntary Manslaughter.
Case 17: DV perpetrator shot domestic violence victim in the chest with 12-gauge shotgun, after threatening to testify against her in her ex-husband's case seeking custody of her oldest child.	Sentenced to life in prison plus five years to run concurrent.
Case 18: DV perpetrator stabbed domestic violence victim 4 times in the neck and head within 5 hours of his release on his own recognizance for battery charges against her. The perpetrator killed the victim with a screwdriver which was left lodged in her skull. The victim remained in a coma until she gave birth to a child and she later died.	Pled to Voluntary Manslaughter. Sentenced to 20 years in prison.
Case 19: DV perpetrator stabbed domestic violence victim to death outside her apartment. DV victim had a TPO in purse which she had obtained just 8 days before her death.	Pled guilty to Voluntary Manslaughter and Aggravated Stalking. Sentenced to 20 years plus five years concurrent.
Case 20: DV perpetrator stabbed domestic violence victim multiple times in neck with pocketknife on her birthday, after a long separation.	Life with possibility of parole.
Case 21: DV perpetrator stalked domestic violence victim, shot her in her dentist's office, and then shot and killed himself in front of the victim's dentist and office staff. At the time of her death, the victim had a TPO and the couple's divorce was pending.	Deceased perpetrator.
Case 22: DV perpetrator strangled domestic violence victim to death and slept in bed with corpse overnight. The perpetrator had been convicted of strangling another woman who survived and had a documented history of strangling women.	Pled guilty to Voluntary Manslaughter.
Case 23: DV perpetrator strangled domestic violence victim to death in her home & set her house on fire to destroy evidence. At the time he committed the homicide, this perpetrator was on probation, had 2 criminal charges pending against him, and the police had been called over 20 times.	Pled guilty to Felony Murder, Arson, and Burglary. Sentenced to life in prison with no chance of parole for 75 years.

Case 24: DV perpetrator shot domestic violence victim 6 times with a 22-caliber gun in the head and torso while she was in bed. Her teenage so was asleep in his room. The DV perpetrator fled the scene, then later shot himself.	Deceased perpetrator.
Case 25: DV perpetrator shot the victim while she was in her car leaving their apartment complex after having retrieved her belongings with a police escort and family support. Victim died in her mother's lap. Victim's mother was also shot but survived. Perpetrator killed himself.	Deceased perpetrator.

Note: Many of the perpetrators in reviewed cases had prior contact with the police and courts. For more information about this, refer to the Civil and Criminal History section of this report.

Table: Types of Homicide

Types of Homicide	Number of Cases	% of cases
Single Victim	14	56.0%
Homicide/Suicide	5	20.0%
Homicide/Attempted Suicide	1	4.0%
Multiple Homicide/Suicide	1	4.0%
Homicide/Suicide/Attempted Homicide of Others	1	4.0%
Homicide/Attempted Homicide of Others	2	8.0%
Multiple Homicide	1	4.0%

Table: Cause of Death

Cause of Death	Number of Cases	% of Cases
Gun shot	12	48.0
Stab wounds	6	24.0
Strangulation	5	20.0
Sharp force trauma/probable asphyxia	1	4.0
Multiple traumatic injuries	1	4.0

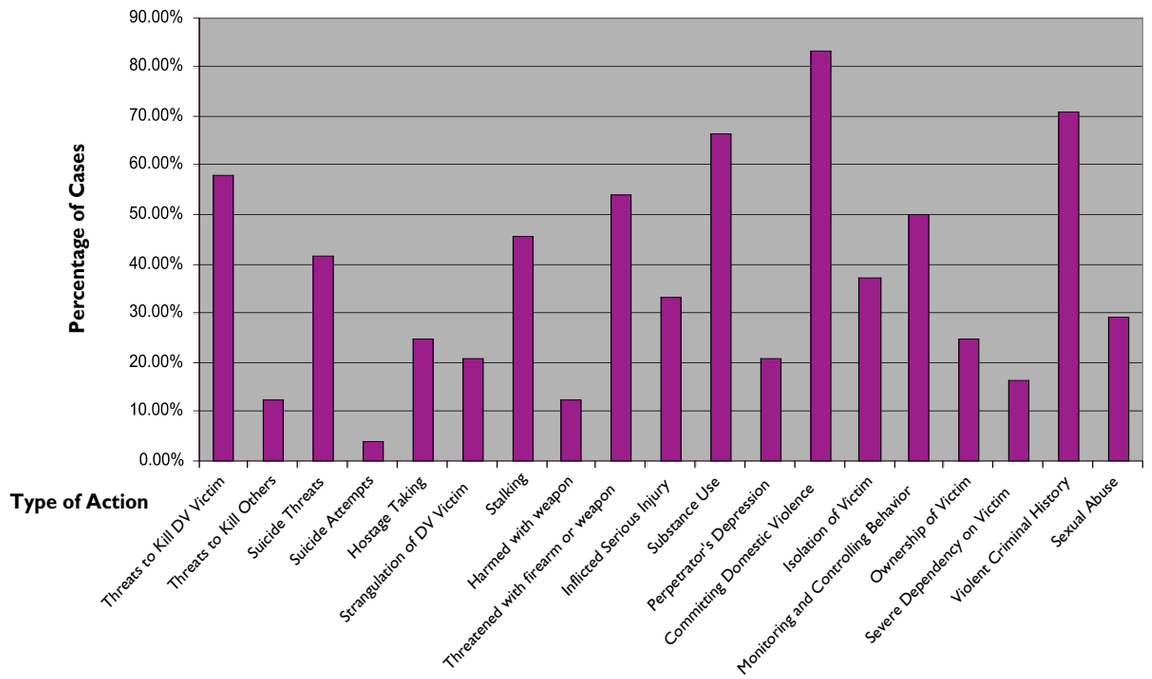
Table: Who was Present at the Fatality

Person(s) Present at Homicide	Number of Cases	% of Cases	Number of Persons	% Who Witnessed Homicide	Number of Witnesses Injured at Homicide	Number of Witnesses Killed at Homicide
Children	15	60.0%	30 children	60%	2	1
Domestic Violence Victim	1	4.0%	1	100%	1	0
Family Members	5	20.0%	7 family members	86%	2	2
Friends	2	8.0%	2	100%	0	0
Acquaintances	2	8.0%	2	100%	0	0
Strangers/Dentist	1	4.0%	3	100%	0	0

Section 3: Domestic Violence Perpetrator's History of Abuse and Other Lethality Indicators

Domestic violence perpetrators engaged in a large number of abusive tactics over the course of their relationship with the domestic violence victim. Threats to kill the domestic violence victim, threats made with a weapon or firearm, violence in criminal histories, and domestic violence were evident in over half of the histories of the domestic violence perpetrators. In addition, over 60% of the domestic violence perpetrators had histories of substance use. In addition, over 20% of their histories documented evidence of the domestic violence perpetrator's attempts to gain power and control over the victim through isolation, monitoring and controlling behavior, and ownership of her. The information detailed in the following chart contains that of what we knew from interviews with family and friends and from public records-- but it would be safe to assume that there is more than we can possibly know.

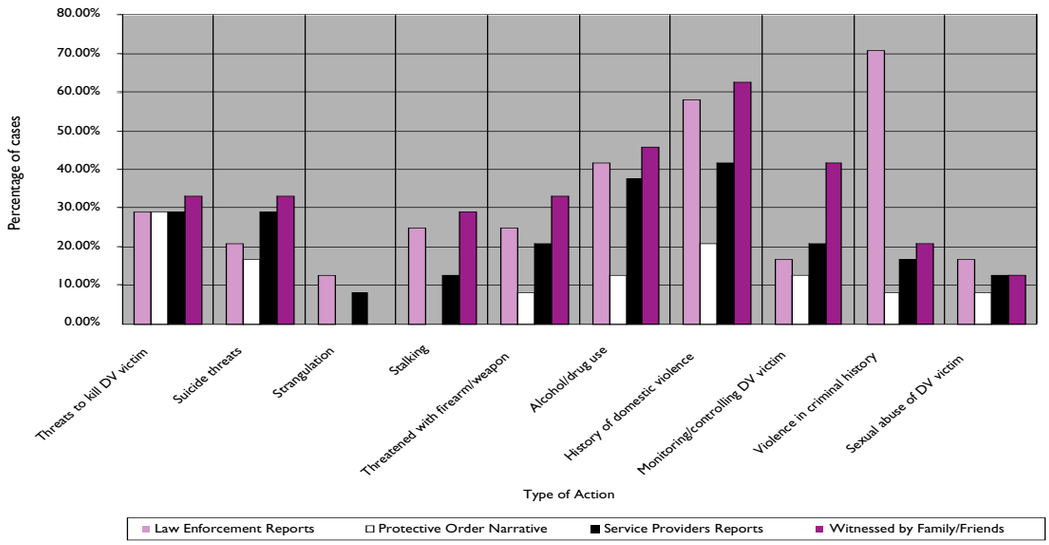
Perpetrator's History of Abuse



NINA ALBRIGHT, AGE 23, WAS BLUDGEONED TO DEATH BY BLOWS TO HER HEAD BY HER LIVE-IN PARTNER AND FATHER OF HER DAUGHTER, IN THE KITCHEN OF THEIR HOME. HE ATTEMPTED SUICIDE BUT SURVIVED.

The sources of information relied upon to document the abusive histories of the domestic violence perpetrators included law enforcement reports, protective order narratives, service providers reports, and statements from families and friends that they witnessed such abusive actions. The percentage of cases documenting the domestic violence perpetrators abusive actions by its source is presented in the following chart for a selected number of behaviors.

DV Perpetrators' Actions by Source



In nearly 60% of the cases there was evidence that the perpetrator was violent towards others. In six cases there was evidence of at least one prior incident; in five cases two prior incidents were noted. In two cases three prior acts of violence with others were documented. In one case, five prior violent interactions with others were noted. In only one case was there known evidence that a DV perpetrator was violent towards animals; research would indicate the rate would be much higher, and this data may reflect a need to create additional strategies to get at this data.

Table: Violence to Others/Public

Type of violence	Number of Cases	Number of Prior Incidents of Violence to Others
No known violence to others	10	
Bar fights, violence to people other than current domestic violence victim	6	1 known prior case
Same as above	5	2 known prior cases
Same as above	2	3 known prior cases
Same as above	1	5 known prior cases
Violence toward animals	1	1 known prior case

VIVIAN BELL, AGE 39, WAS STABBED TO DEATH WITH A POCKETKNIFE ON THE SIDE OF A COUNTRY ROAD BY HER HUSBAND, ON HER BIRTHDAY.

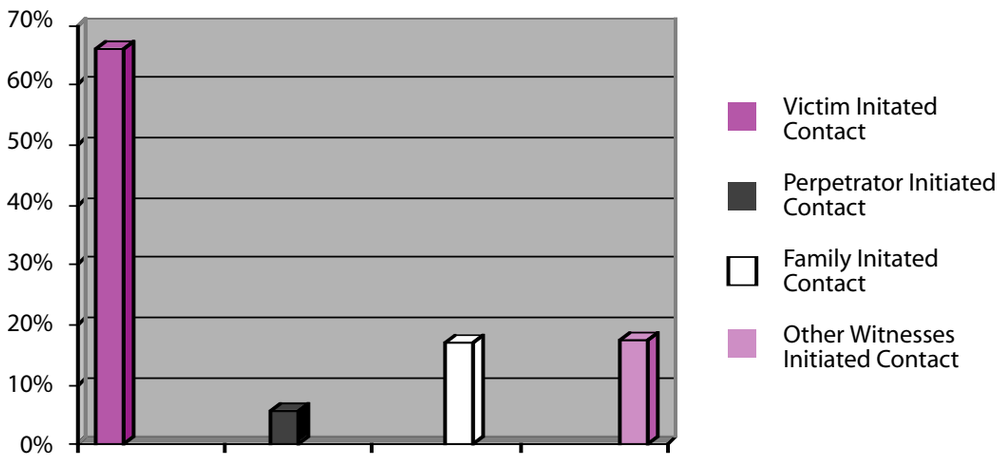
Section 4: Civil & Criminal History: Law Enforcement, Prosecution, and Sanctions

Prior to the homicide, 20 of 24 perpetrators had contact with the criminal justice system; this data is not known in one case. The number of contacts ranged from 0 (4 cases) to 19 (1 case). In four of the 20 cases where prior contact with the criminal justice system was noted, there was indication that the domestic violence perpetrator and the domestic violence victim had multiple contacts with law enforcement agencies, possibly in multiple jurisdictions. However, in only five cases was the Fatality Review Team able to obtain information from all agencies known to (or suspected of) having contact with the victim and perpetrator. Thus, it is likely that the contacts detailed here underestimate the true extent of contact the domestic violence perpetrator had with the criminal justice system.

The total number of criminal justice contacts for the 20 cases that had prior contact with the criminal justice system was 88. For 82 of the 88 contacts (93.2%) the date of police contact was available. The earliest police contact was in 1964 and the most recent police contact was in 2004; only four prior police contacts occurred before 1990.

Initial Contact with the Police

For almost one quarter of the cases (23.9%) it was not known how the police were initially contacted. From available information, it appears that a call to 911 was the leading means by which police were contacted (77.6%). In about 7% of the contacts the victim sought police assistance by traveling to the police station. In one instance the hospital called the police on behalf of the DV victim. The following chart details who sought out the initial police contact.



In 65 of the 88 contacts information was available as to whether or not police were dispatched in response to an incident. Police were not dispatched in only two incidents. In one incident the domestic violence victim sought out a warrant, but it was not granted by the judge. In the second incident the victim came to the station and gave a statement to the police.

In 55 of the 88 incidents, the type of call to which officers were dispatched was recorded. In over half of those incidents (54.6%) police were dispatched to a domestic disturbance call. In close to half (44.3%) of the contacts with police, the domestic violence victim was on the scene when the police arrived, whereas the perpetrator was on scene in less than one third of the cases (28.4%).

In slightly more than one quarter of the incidents (26.2%), information was missing as to whether or not the police filed a report. Sixty percent of the time police did file a report documenting the call for service. No information was available as to why a report was not filed in 12 of the contacts.

Table: Types of Charges Filed by Police (n=53)

Type of charge:	Number (%)*
Simple battery (non-FVA)	11 (20.8%)
Family Violence battery	4 (7.5%)
Suicidal person	2 (3.8%)
Shoplifting	2 (3.8%)
Criminal damage to property	2 (3.8%)
Simple assault	1 (1.9%)
Disorderly conduct	1 (1.9%)
Aggravated assault	1 (1.9%)
Terroristic threats	1 (1.9%)
Violation of FVA unspecified	1 (1.9%)
Missing person	1 (1.9%)
Simple battery and theft	1 (1.9%)
Simple battery and interference with 911 calls	1 (1.9%)
Simple battery and false imprisonment	1 (1.9%)
Disorderly conduct and obstructing an officer	1(1.9%)
FV battery and simple battery	1 (1.9%)
Sexual battery and false imprisonment	1 (1.9%)
Aggravated assault, terroristic threats, and battery	1 (1.9%)
Aggravated assault, criminal damage to property, and pointing a pistol	1 (1.9%)
Not specified	18 (33.9%)
**Percentages may not add to 100 due to rounding.*	

The types of charges filed by the police were quite varied as seen in the above table. In only 29 incidents was there information available as to whether or not the suspect had a gun. In slightly more than half of these 29 incidents the suspect did have a firearm, but in only two incidents were there records that the police officers did confiscate the firearm.

In one quarter of the police incidents it was unknown whether or not police made an arrest of a suspect. In those incidents where information on arrest was available, police arrested a suspect in just about half of the incidents (54.5%). In the 30 incidents where police did not arrest a suspect, no information was available to determine why police did not arrest in half of the incidents. The leading justifications for police failure to arrest were that the suspect was not present at the scene (26.7%) or that probable cause was not established (20%). In three incidents where police did not arrest, they later swore out a warrant for the suspect's arrest and in eight incidents police instructed the victim to swear out a warrant for the suspect's arrest. In 4 known cases, the domestic violence victim who was murdered was arrested by the police during a prior domestic violence call. In one

case, the police arrested both people, and in 3 cases the police arrested the homicide victim only.

In slightly less than half of the prior incidents where police were called, it was noted that victims received injuries. Information was available on the extent of injuries to the DV victim and is presented in the following table. Records indicated that in six incidents, domestic violence victims required medical attention and four domestic violence victims were transported to the hospital. In less than half of the incidents information regarding whether or not law enforcement took photographs was available. Law enforcement took photographs of injuries in only six incidents. In only eight incidents was there evidence verifying that law enforcement gave information about resources to domestic violence victims. In none of the initial contacts with police was there any indication that the domestic violence victim or the perpetrator needed an interpreter. In seven of the incidents, police did a follow-up investigation. In over two-thirds of the incidents, information on whether or not police forwarded the case for prosecution was available. In 34 of 58 incidents (59% of incidents with information available) law

Table: Prior Injuries Known in Reviewed Cases as Noted in Police Reports

Injuries Reported by DV Victims (n = 42)	
Type of injuries:	Number (%)*
No injuries	18 (42.9%)
Bruises on body	3 (7.1%)
Neck injury, broken blood vessels due to strangulation	3 (7.1%)
Scratches and cuts	2 (4.8%)
Soreness	2 (4.8%)
Red marks on shoulders	2 (4.8%)
Head injuries	2 (4.8%)
Bruises, cuts, and contusions	2 (4.8%)
Struck in face	2 (4.8%)
Unknown injuries	2 (4.8%)
Scratches	1 (2.4%)
Cuts on forehead	1 (2.4%)
Stab wounds	1 (2.4%)
Eyes burned by substances	1 (2.4%)
**Percents may not total to 100 due to rounding.*	

enforcement did forward the case for criminal prosecution.

Criminal Prosecution of Violence Prior to Homicide

Records indicated that in 23 incidents, suspects were taken into custody, and in 13 incidents they were held in jail for one day prior to release on bail/bond. Bail amounts ranged from $180 to $5,000. In twenty of the 23 incidents where suspects were in custody, suspects were released prior to arraignment on criminal charges. In seven incidents suspects had conditions attached to their pre-trial release and in five incidents a No Contact Order was in place.

In 40 percent of the incidents forwarded for prosecution (14 cases), the prosecutor's office attempted to contact the victim and was successful in close to 80% of the time. Prosecutors typically contacted victims through letters. Typically domestic violence victims talked with victim advocates employed by the prosecutor's office. Charges were filed against the perpetrator in about 88% of the cases forwarded to the prosecutor by the police.

The 34 incidents resulted in a total of 59 charges being filed by prosecutors. Close to half of the charges were for violent offenses including: attempted murder, battery, aggravated assault, or aggravated stalking. Slightly over 18% of the charges were for driving violations such as driving while impaired, driving with a suspended license, or driving with no proof of insurance. Property offenses comprised over 15% of the charges. The remaining charges included disorderly conduct charges, weapons charges, and violations of probation or parole conditions. Prosecutors accepted plea bargains and/or dismissed charges in 39% of the incidents. Between the initial contact with the police and the trial date a new assault, a violation of protective order, or additional call to law enforce-

ment in response to domestic violence by the suspect occurred in seven incidents.

Until we look at it in a chart, it is hard to really appreciate the difficulties these cases had in reaching a judge or jury. The following chart shows the progressive loss of cases preceding the homicide as they worked through the

Table: Progressive Loss of Cases

Original Event	Description	% of Known Total Cases
88 Calls to Police		
58 Calls to Police	Where case outcome is known	
34 Cases	Forwarded by Police to Prosecutor	58.6
30 Cases	Charged by Prosecutor	51.7
12 Cases	Dismissed or Pled Down	20.6
18 Cases	Proceeded as Charged at scene	31.0

criminal legal system.
To summarize, of the known cases, just over half made it to the prosecutor's office and less than one third made it to court as originally charged.

12 of the perpetrators had felony convictions prior to the homicide.

Criminal and Civil Dispositions and Sanctions

In the 24 cases reviewed, at least six domestic violence victims had TPOs in place and five victims had permanent protections orders in place at the time of the fatality.

The criminal dispositions for each of the criminal charges were available for 45 of the 59 charges levied by prose-

Table: Criminal Dispositions for Charges Filed Prior to Homicide

Criminal Dispositions for Charges (n = 45)	
Disposition:	Number (%)*
Guilty	22 (48.8%)
Plead guilty to reduced charge	10 (22.2%)
Open at time of fatality	5 (11.1%)
Nolle Prosse	3 (6.7%)
Diverted from prosecution	2 (4.4%)
Deferred sentence	1 (2.2%)
First offender act invoked	1 (2.2%)
Existing probation revoked	1 (2.2%)
**Percentages may not total to 100 due to rounding.*	

ROBIN SUZANNE STEADMAN, AGE 28, WAS SHOT ONCE IN HER HEAD BY HER EX-HUSBAND. ROBIN DIED WITH HANDCUFFS ON ONE WRIST AND THE KEY IN HER OTHER HAND.

cutors. The dispositions are presented in the following table.

Information on the sanctions imposed was available for all but two of the 34 criminal incidents. For some of the incidents (n = 10), those where the disposition involved diversion, a deferred sentence, first offender status being awarded, a nolle prosse, or the case was still open, no sanction was imposed. Thus, for 26 incidents, information on the type of sanction sought by the prosecutor, whether the court imposed that sanction and the length or amount of the sanction (if applicable) was obtained from the files. The types of sanctions imposed ranged from probation, incarceration in jail or prison, fines, restitution, and community service. Also imposed were referrals to programs including Family Violence Intervention Programs (FVIP), substance abuse treatment, anger management, parenting classes, mental health evaluation and mental treatment.

For 14 cases (38%) of the criminal incidents examined information was available on the type of court that issued orders and monitored probation. Half of the court orders were issued in state court; 42.9% were issued in the superior court; and 7.1% in municipal and state court. Over half of the courts utilized probation, but information on the type of probation services available (private, county or state) and the amount and type of contact probation officers had with the victims was available for only about five incidents. This information suggests that probation officers do not commonly interact with domestic violence victims and none reported having contact with the victims whose fatalities were reviewed. Further information on the conditions of probation supervision imposed by the court was not available except in two incidents.

In 9 known cases, the perpetrator was subject to legal sanctions which carry a prohibition against possession of firearms. The following chart shows these cases.

Table: Periods of Time When DV Perpetrators Had Firearms

Periods of Time When DV Perpetrators Had Access to Firearms	
Time Period:	**Number of cases**
While protective order was in place	1
While protective order was in place and pre-trial	1
While protective order was in place, during pre-trial and following disposition of criminal case	1
During pre-trial period	2
Following disposition of criminal case	1
While on probation	1
While on probation and parole	2

In only one known case did the court request that the DV perpetrator surrender firearms. If other courts did, the review teams could find no record of it. There was evidence that the victim directly requested the police to remove firearms from a residence that was shared by the victim and perpetrator. In three cases firearms were removed from the home and in two of these cases the perpetrator voluntary surrendered the firearms. In one case, numerous firearms were transferred to the perpetrator's family member, in whose car the perpetrator left the scene.

Family Violence Intervention Programs (FVIPs)

Valid information on the number of times that the domestic violence perpetrator had been ordered to a FVIP was available for only 10 of the 24 fatalities reviewed. Only three out of the ten perpetrators had been ordered to an FVIP. Six of the 10 perpetrators had not completed an FVIP. In six of the cases perpetrators attended an FVIP that used the Duluth model of intervention. In only one case was there evidence that the FVIP screened for depression and suicide.

KELLY LYNN WATT SNOW, AGE 36, WAS MURDERED BY BLUNT TRAUMA TO THE HEAD WITH A POKER IRON AND LIGATURE STRANGULATION WITH A TELEPHONE CORD BY HER HUSBAND IN THE LIVING ROOM OF THEIR HOME.

Section 5: Community Systems Involved in the 5 Years Prior to the Homicide

The Domestic Violence Fatality Review teams identified agencies and community entities or systems that the domestic violence victim and/or perpetrator were involved with in the five years preceding the fatality under review. The num-

Table: Agencies Involved with Victim or Perpetrator in 5 Years Prior to Homicide

Agencies/Services/Programs Involved with Victim or Perpetrator in Past Five Years		
Agency/Service/Program	Number of DV Victims	Number of DV Perpetrators
Justice System Agencies: Law Enforcement Agency	19	22
City Prosecutor	1	3
County Prosecutor	8	11
Magistrate Court	10	10
Municipal Court	1	3
State Court	7	12
Superior Court	8	11
Civil Court (Divorce)	6	5
Court Based Legal Advocacy	5	1
Protection Order Advocacy	7	0
Probation	3	12
Parole	0	3
Legal Aide	1	0
Social Service Agencies Child Protective Service (DFCS)	1	1
Child Care	1	0
WIC	1	0
TANF/Food Stamps	1	0
Homeless Shelter	1	0
Health Care Agencies Mental Health Provider	4	5
Medicaid	1	0
Peach Care	1	0
Private Physician	1	1
Emergency Care	3	0
Hospital Care	4	5
Emergency Medical Service	5	0
Substance Abuse	1	1
Family Violence Agencies Shelter or Safe-house	6	0
Sexual Assault	1	0
Community Based Advocacy	8	2
Family Violence Intervention Program	0	6
Miscellaneous Agencies Faith Based	6	4
Immigrant Resettlement	1	0
English as a Second Language	1	0
Anger Management	0	1

ber of cases reporting contact by type of agency is listed in the following table.
Prior to the fatality, DFCS/Child Protective Services (CPS) was involved with only two cases. In one case a referral to CPS was made that resulted in a substantiated occurrence of child abuse/neglect. In both cases substantiated abuse/neglect by the domestic violence perpetrator was made. In one of the cases there was evidence that the CPS worker screened for domestic violence.

The review teams also attempted to identify how many victims sought shelter during the relationship with the domestic violence perpetrator and if there were any barriers that seemed to impede the domestic violence victim if she was seeking to escape the relationship. Evidence suggests that three victims had sought safety in a domestic violence shelter. One was successful in obtaining shelter and remained there for one night. One case reported that the victim did not have transportation to the shelter and law enforcement would not provide such transportation. Another victim reported seeking and obtaining shelter with family and friends.

Barriers noted in the reviews included the law enforcement and the court system's failure to hold the domestic violence perpetrator accountable for his violent or criminal actions. In eleven of the 24 cases, the fatality review team members noted this failure. It was evidenced in failure to follow through on violations of TPOs, law enforcement threatening to arrest the domestic violence victim when responding to calls, and failing to impose meaningful sanctions when the domestic violence perpetrator engaged in criminal behaviors unrelated to domestic violence, such as chronic driving violations in one case. In at least eight cases, the lack of financial resources and/or the dependency of the DV victim on the DV perpetrator for housing or transportation were mentioned as a barrier. In at least four fatalities, the lack of knowledge about domestic violence and lack of community outreach to victims was mentioned. In two cases victims' addiction to illegal drugs was noted as a barrier to trusting law enforcement. Lastly, in three cases domestic violence victims were concerned about the potential loss of custody of her children if domestic violence was reported.

DAMITA OGLESBY, AGE 30, WAS PREGNANT WHEN HER LIVE-IN PARTNER STABBED HER WITH A SCREWDRIVER IN HER NECK AND HEAD. DAMITA GAVE BIRTH WHILE IN A COMA, AND DIED SHORTLY THEREAFTER.

Findings and Recommendations

The findings and recommendations found below came directly from the 13 task forces that participated in the Fatality Review process. Broken down into two main sections, the first grouping of findings and recommendations relate to community response systems and the second grouping relates to legal response systems. While these findings and recommendations came from local review teams, the same things were often found across the state, and therefore may be generally relevant and useful statewide.

Community Based Findings and Recommendations

Barriers for victims to receive assistance from all the systems

Finding: Several review teams around the state made one general finding: that many responders have pre-conceived ideas of "good or innocent" victims and "bad" victims. For example, when victims had been arrested for domestic violence, had alcohol/drug addiction, engaged in self-defense or questioned shelter rules, some responders did not work as hard for these victims. In addition, if victims did not fit pre-conceived notions of victimization, i.e. sadness, emotion, and disclosure, some responders had difficulty recognizing the danger these victims faced.

Recommendation: All responders in all systems should receive training on cultural differences in responses to trauma, self-defense, as well as training on the intersection of trauma with other life difficulties such as poverty, addiction, racism and mental illness.

Childcare Centers

Finding: Childcare workers interact with children who witness domestic violence and they are potential responders.

Recommendation: Basic domestic violence education with childcare workers is important. The training should include basic signs to identify safety and security issues at day care centers, general safety issues for victims, and how to get help.

Finding: Childcare facilities are one of the few places perpetrators allow victims to go.

Recommendation: Domestic violence information should be placed in all day care centers for victims.

Community Outreach and Education

Finding: There are cases where perpetrators cut a wide path of destruction having many victims, connecting with numerous systems, even being known as a danger in the community. However the systems were disconnected from one another leaving isolated snapshots of the big picture. Also, each person may have known the potential danger the victim was in, but felt unprepared to marshal a coordinated response among all those involved or knowledgeable about the violence in her life.

Recommendations:

1. Every major system that responds to victims and offenders should actively participate in the local domestic violence task force and the fatality review team.
2. Domestic violence task forces should create a subcommittee focusing on community outreach and education that educates non-traditional responders about indicators of danger, and how to respond in coordination with appropriate agencies.
3. Domestic violence task forces should partner with Chambers of Commerce to assist all businesses licensed at city hall to get the word out about domestic violence.
4. Communities should engage in formal safety audits to do a formal inventory of how systems do and do not respond in a coordinated fashion to victims and offenders.

(See Employer Section)

Finding: Friends, family and co-workers were hesitant and choose not to become involved in assisting the victims in several cases just prior to the homicide. Some didn't understand the potential lethality of the given situation, some believed it was wrong to interfere in a couple's relationship, some saw it as a drug and alcohol issue and others felt it would get better on its own.

Recommendation: The domestic violence task force should engage the public to respond to friends, co-workers, and family members who are abusers or victims, by getting the word out generally about domestic violence using means such as Public Service Announcements (PSA), public information campaigns distributing information cards with paychecks, monthly bank statements, billing statements, children's report cards, drug prescription bags, public transportation poster campaigns, health and job fairs, community festivals, etc.

Ideas for PSAs include:
- Breaking the silence about domestic violence
- Basic education on how to help someone you know or love that is a domestic violence victim
- Men standing up and against domestic violence
- Engaging public servants, community leaders and elected officials to lend their voice to making domestic violence intervention a community priority
- Faith Communities from all religions standing united against domestic violence
- Education breaking stigmas about who is a victim
- How to get help

Finding: Fatality Review Committees emphasized the importance of prevention, outreach and education and the need for collaborative community response in the cultural context of the diversity of families experiencing domestic violence.

Recommendations: Community outreach efforts should specifically address cultural norms of violence and fear of public systems that some communities may experience. All prevention, outreach, and education efforts should be culturally sensitive, culturally relevant and language accessible.

Finding: Victims are not made aware of their rights according to state law.

Recommendation: Add Victims' Bill of Rights to all brochures informing victims about domestic violence.

Finding: Transient communities breed a culture of silence and many have a widespread fear of being arrested and generally do not want to get involved in court processes. The smallness of these communities also make anonymous reporting difficult, so many people do not call the police or reach out to those who are being abused that may be living right next door.

Recommendation: Transient communities, such as apartment complexes and extended stay hotel/motels should place domestic violence information in leases and in public areas.

Counseling and Mental Health Services

Finding: Some private practices that were teaching "anger management" and "domestic violence classes" before the state required certification have chosen not to become state certified to offer FVIPs. These programs are continuing to practice outside the scrutiny of the Department of Corrections (DCOR) and GCFV, and many continue to engage in outdated and dangerous intervention strategies.

Recommendations:
1. Courts should comply with the certification statute and not send domestic violence offenders to non-certified programs.
2. Programs which desire to work with domestic violence offenders should complete the required training and become certified through the Department of Corrections, to ensure they do not engage in interventions which further increase the danger in these cases.
   (See FVIP Section, and find the list of certified FVIPs at www.dcor.state.ga.us)

CAROLYN JEANINE WILLIAMS LACKEY, AGE 35, WAS SHOT IN THE HEAD BY HER HUSBAND WHILE SHE SAT ON THE SIDE OF HER BED IN THEIR HOME.

Department of Family and Children Services (DFCS)

Finding: Surviving children of domestic violence homicides are not receiving adequate follow-up services once placement has been made (i.e., therapy for witnessing the homicide or seeing or discovering the deceased victim).

Recommendation: Surviving children's emotional/mental health should be made a priority once they are stable with other family members or foster care. All surviving children should receive professional counseling with therapists who specialize in grief and trauma.

Finding: DFCS case plans in domestic violence cases are often made for both the victim and the perpetrator rather than making separate plans, and they often include a requirement that the perpetrator attend a FVIP. Putting this requirement in a case plan designed for both parties, instead of a separate case plan for the offender, makes the victim responsible for the perpetrator's actions.

Recommendation:

1. Case management plans should be developed in collaboration with domestic violence advocates. The focus of case plans should include the adult victim's safety and well-being because protecting mothers helps to protect children.
2. Punitive sanctions should be placed on domestic offenders--not on victims--regarding what the perpetrators are required to do. To create a more positive result for children, DFCS should engage with other systems designed to hold perpetrators accountable for their violence by reporting it to law enforcement, probation and parole officers, prosecutors and judges,

Finding: DFCS caseworkers are placed in harm's way daily, especially when dealing with a family where there is domestic violence.

Recommendation: DFCS caseworkers should have training on indicators of danger and have access to a law enforcement officer to assist on high-risk visits to ensure safety of the caseworker.

Drug and Alcohol Treatment Facilities

Finding: State certification and license does not require domestic violence education. This causes many difficulties when dealing with the accountability of perpetrators and the safety of victims.

Finding: Strict state regulations regarding recovering addicts' confidentiality limit the ability of counselors and facilities to work with other systems in holding abusers accountable and in keeping victims safer.

Finding: Drug and alcohol treatment facilities often include family in the treatment program and may fail to consider domestic violence in the context of the addict's treatment. This results in the domestic violence remaining unspoken, and leaves many victims in greater danger as many will participate in the addict's treatment.

Finding: Drug and Alcohol treatment programs do not allow law enforcement into their facilities to serve warrants, allowing abusers who admit themselves, to avoid service of warrants and civil TPOs. At the same time, shelters cannot offer that degree of confidentiality to victims.

Recommendations:

1. All domestic violence task forces should recruit drug and alcohol treatment counselors to the task forces and the fatality review process.
2. The state entities over the drug and alcohol counseling certification/licensing should be approached to include domestic violence training, including research on the lack of a causal relationship between the two problems, and strategies for simultaneous intervention for both.
3. Drug and alcohol facilities should cooperate with local law enforcement regarding officers serving warrants and civil orders to residents, and amend any confidentiality agreements to permit them to do so.

Finding: Some domestic violence victims use drugs and alcohol as a way of self-medicating due to trauma. In some cases, abusers used drugs as a means of power and control over victims by coercing or forcing victims to use drugs or by secretly administering them.

Finding: Some offenders will make false allegations of drug or alcohol dependency to other systems such as DFCS or the police to reduce the likelihood they will believe or assist the domestic violence victim.

Recommendations:

1. Systems in place to assist victims should not let a victim's drug and alcohol use and addiction deter them from providing services.
2. Shelters and other response systems that can help address addiction should train staff to evaluate basic addiction issues and have knowledge of community resources available for the victim.

Employers

Finding: The majority of employers do not address the issue of domestic violence within their human resource departments.

Finding: Some domestic violence victims are sometimes disciplined or fired as a result of perpetrators harassing and threatening the victim, her coworkers and supervisors. Victims are also fired as a result of having to take time off from work to file TPOs, warrants, and attend hearings and trials.

Recommendation: Domestic violence organizations should reach out to major employers in their area and offer free training with all employees, with a focus on: basic domestic violence information and how to get help, how supervisors and other employees respond in the workplace, and how to develop a company policy on domestic violence addressing both victims and abusers as employees, detailing when the company may take to a TPO against the abuser, modify disciplinary procedures around victimization, modify leave policies for court hearings, and assist with safety planning in and out of work.
(See Community Outreach and Education and Immigrant and Refugee Sections)

Faith-Based Organizations/Community

Finding: Leaders in the faith community may approach domestic violence within their congregation as a marital issue versus holding the abuser accountable for the violence.

Recommendations:

1. Faith leaders should hold abusers accountable for their behavior as a crucial component for victims' safety and work in coordination with local victim advocates to create victim centered, individualized safety plans.
2. Faith leaders should seek out domestic violence agencies to provide training for clergy and congregation members.

Finding: In some communities there is resistance among faith-based organizations to involve outside agencies when dealing with domestic violence within their congregation. Some believe that any involvement outside of their faith would be contradictory to their beliefs and values.

Recommendation: Faith-based communities should collaborate with domestic violence agencies that can consult with clergy about specific cases and provide direct assistance to the victim which complements the faith-based counseling.

Finding: Faith-based communities are underrepresented on domestic violence task forces. Some task forces found it difficult to reach out to faith-based communities as a whole and found themselves immersed in tensions among different faith communities.

Recommendation: Domestic violence task forces should reach out to faith communities one at a time, not as a whole-- incrementally building support in religious communities. Furthermore, faith leaders should join their local task forces.

Family and Friends

Finding: Surviving families and friends are deeply impacted by domestic violence homicide, yet most are not connected to advocates or other helping professionals who could assist them in many of the effects of the homicide, including:

- Severe consequences of grief
- Unexpected child rearing responsibilities for the children of the deceased
- Unique parenting challenges for children who have lost a parent(s) to homicide
- Economic impacts including child rearing costs, funeral costs, resolving financial issues of the deceased, etc.
- Difficulties in evidence/property recovery
- A profound sense of betrayal and alienation from the community, particularly when the family had been involved in several systems prior to the fatality

Recommendation: GCADV and GCFV recommend that a centralized human services broker be funded and hired to reach out to surviving family members, identify needs, locate resources, link families to resources, and follow up. We recommend that the broker not be identified with any responding system or agency, as many families felt significant anger toward such agencies for how they did or did not help their loved one, or how they handled the homicide case.

Health Department

Finding: Many domestic violence victims turn to health departments for needed services.

Recommendations:

1. Domestic violence brochures in different languages should be made available in the lobby and in bathrooms of all of Georgia's Public Health Departments.
2. Domestic violence information classes should be offered to the general public through Public Health Departments, titled more generically (i.e. "life-training" etc.) to allow victims to be able to access them without interference from their partners.

Immigrant and Refugee Community

Findings: Communities are growing so rapidly that it is difficult to keep up with the demand of the many languages. One county in North Georgia has over 200 dialects. This creates havoc for responding officers, hotlines and shelter intake workers, and courtrooms later. Funds are stretched; even when funds are present for interpreters, the interpreters cannot be found in some counties.

Recommendation: Approach local employers, especially the businesses that are employing the new immigrant and refugees, for funding for interpreters, telephone line interpreter services for the shelters and English as a Second Language (ESL) or English for Speakers of Other Languages (ESOL) classes.

Finding: Non-English speaking victims of domestic violence are often fearful of reporting abuse to law enforcement due to language barriers and possible consequences surrounding their immigration status.

Finding: Interpreters for non-English speaking victims are not always provided during law enforcement intervention and court proceedings.

Finding: Several Fatality Review Committees agreed that more outreach needs to be done for marginalized segments of their population, but they lack the tools and resources to achieve this in a meaningful way.

Recommendations:

1. Distribute domestic violence brochures at vocational schools and in ESL/ESOL classes.
2. Tapestri Refugee and Immigrant Coalition should be consulted to provide training to task force about assessing community need and initiating relevant outreach to multi-cultural communities.
3. Domestic violence task forces need to formally assess the barriers to interpreters being provided as required by law and develop plans to bring the community into compliance.
4. Multi-language brochures are needed with information about safety planning.

Finding: Service industries such as hotels employ a high number of immigrants and refugees.

Recommendation: Corporations and industries that employ a high number of immigrant and refugees need domestic violence awareness training for employers and employees and multi language domestic violence brochures in common areas. (See employer recommendations for more general recommendations). Human Resource managers and Employee Assistance Programs should be provided with language-based resources. (See Employer Section)

Legislation

Finding: Offenders are bonding out on a schedule-- without adequate time for victim notification or judicial scrutiny of the danger the Defendant poses to the victim and the community.

Recommendations: State law should be clarified to ensure that offenders cannot bond out of jail on a domestic violence charge without going before a judge.

Finding: Arresting batterers on bond conditions, i.e. Stay Away Orders, is near impossible because officers cannot confirm that these orders exist when responding to a call.

Recommendation: Georgia needs a TPO statute that is attached to the Family Violence Act, allowing TPOs to be granted in criminal court allowing for the TPO to be entered into the registry at the time of the hearing. (See Judicial and Law Enforcement Sections)

Media

Finding: Some news reporters inadvertently misinform the public about domestic violence by how they cover domestic violence, particularly homicides. Headlines about domestic violence homicides often refer to "disputes", or cover the death as though it was the fault of the victim or both parties, i.e. a homicide news article entitled, "Nagging led to stabbing."

Recommendations:

1. Task forces should assign person(s) or subcommittees to keep track of local media's reporting on domestic violence cases and bring it to the tasks force's attention when a story or headline is inappropriate. Task forces should contact, educate and build relationships with news media.
2. Offer basic domestic violence training to reporters.

Medical

Finding: Medical care providers have multiple opportunities to screen patients for domestic violence and provide them with support and referrals.

Recommendation: Medical care providers should develop a consistent policy for screening patients for domestic violence. Patient intake forms should include the question "Do you feel safe at home?" Staff should be trained and prepared to handle patient responses to this question.

Finding: Dentists are seeing victims of domestic violence for routine visits while they have visible injuries to their mouths, but may not ask if the patient is being abused.

Recommendation: Dentists need to be included in trainings for medical professionals. They also need to have a screening and referral policy for domestic violence.

Finding: Women receiving pre-natal care need to be screened for domestic violence. While nationwide statistics say that homicide is the leading cause of death to pregnant women, in Georgia, two of the cases reviewed were of pregnant women.

Recommendation: Physicians and nurses need to receive training on how pregnancy can increase lethality for abused women, and learn how to routinely screen and respond throughout pre natal care.

Finding: When medical offices are not secured, staff and patients are at risk of harm from violent perpetrators.

Recommendation: Medical professionals should consider creating a safety protocol for their office. They should also consider locked doors with a buzzed entry system on all doors leading from the reception area to the patient treatment area.

Finding: Some hospitals emergency staff advise victims about taking legal action such as filing a warrant after she leaves the hospital.

Recommendation: Medical staff should utilize social workers and local domestic violence advocates who can assist the victim directly while at the hospital. Social workers and advocates can help victims determine the best route of action for them, and can involve local law enforcement if that is what the victim wants. In these cases, law enforcement can come to the hospital to have the report filed there, and if probable cause is established, the officer can take out the warrant.

GLENDA KAY TERRELL, AGE 43, WAS STABBED 30 TIMES WITH A BUTCHER KNIFE BY HER TWIN SISTERS HUSBAND.
HER SISTER, BRENDA SUE ALEXANDER, SURVIVED 14 STAB WOUNDS FROM HIM.

Mental Health Facilities/Hospitals

Finding: Mental health hospitals do not consistently notify Sheriff's departments upon releasing a patient who was an abuser.

Recommendations:

1. Local task forces should have medical professionals on the task force, develop relationships with local hospitals to better understand HIPPA, and develop procedures between law enforcement and hospitals regarding release. Procedures should guarantee that perpetrators who are allowed to enter a mental health facility are not released without notification to law enforcement.
2. Task forces should develop protocols which determine how the mental health hospital, while complying with HIPPA regulations regarding patient privacy, can also notify the victim of the perpetrator's release.

Finding: When abusers have additional issues of mental illness or addiction, these issues may become the focus, versus the crime(s) that individual has committed.

Recommendation: Training for all systems should include information on mental health issues and domestic violence perpetrators, to aid responding systems to view situations of crime in their entirety, not just by misdemeanors or in snapshots.

Schools

Finding: School districts lack the funding to have social workers, or counselors for students. Students do not have a specific source of support for personal and family problems.

Recommendations:

1. Schools need adequate funding for every school to have at least a part time social worker.
2. Task forces and domestic violence programs should educate teachers and other school professionals about warning signs of abuse and witnessing domestic violence such as truancy, bad grades, and changes in behavior.
3. Task forces should create a "school outreach committee" composed of service providers who can develop a relationship with the schools for the purpose of outreach, networking, and referrals.
4. Schools should create a protocol to identify students so that teachers, administrators and counselors are uniformly aware of cases where there is a TPO, and any specific restrictions imposed by the court as to which parent can pick up the child from school.

Finding: Not all schools are addressing the issue of domestic violence and teen dating violence.

Recommendation: Domestic violence and teen dating violence should be included in regular school curriculum in all schools, adjusted for age appropriate content. Open teaching about domestic violence allows children who are witnessing violence at home to seek help, it reduces the taboo nature of this subject, and would create cultural norms that violence is not acceptable behavior.

MARY KAY WOODSON, AGE 41, WAS STABBED BY HER BOYFRIEND OUTSIDE OF HER APARTMENT BUILDING LESS THAN THREE WEEKS AFTER FILING A TPO.

Shelters

Finding: Many shelter staff are not aware of the services that DCOR offers over the internet at their web site, such as information on anyone that has ever served time in a state prison. The system is available to look up any prisoner jailed in any state prison across Georgia and see the crime, amount of time to be served and any other time and felony crime that person has committed. Similarly, the V.I.N.E. victim notification program for felony cases is also unknown among many shelter staff.

Recommendation: Shelter staff should be trained on looking perpetrators up on the DCOR site and offer the information to victims calling on the hotline and shelter residents.

Finding: "One Stop Shops," or co-located community services are valuable points of intervention and advocacy for battered women, provided they have adequate safeguards for information sharing.

Finding: Many hotline workers are not prepared to provide support to family and friends of the domestic violence victim. Oftentimes, they will insist that the victim herself call the hotline. There is a lack of community support and resources for family and friends of domestic violence victims, even though they are in important part of the victim's resources and the community's response.

Recommendation: Provide training to shelter hotline advocates to better prepare them to respond to calls from family and friends. Family and friends should be provided with a safety plan for themselves and informed of the implications that their support of the victim might have on her safety. Family and friends should also be advised to have the victim call the advocate for individualized safety planning.

Finding: Out of 24 cases reviewed, virtually all of the victims were in varying degrees of separation. Some shelters require domestic violence victims to be in immediate physical danger to be eligible for shelter.

Recommendation: Shelter screening policy for immediate danger can be broadened to accommodate victims that are in various stages of ending their relationship. The shelter screening policy should include a "screen in" process, not a "screen out" process.

Finding: Not all shelters are prepared to accommodate victims with active substance abuse issues or mental illness.

Recommendation: Provide training to shelter advocates specifically focused on the intersection of domestic violence, substance abuse, and mental illness. Encourage local programs to build relationships with other agencies in their community that work specifically with substance abuse and mental health.

Finding: Sometimes victims are reluctant to seek shelter due to their beliefs about the desirability of living in a shelter environment.

Recommendation: Domestic violence community outreach and education efforts should include myth dispelling information about shelter life.

Finding: The majority of services provided by shelters are for victims who reside in the shelter. Most of the homicide cases reviewed were of victims who did not or could not go to a shelter.

Recommendation: Expand community-based programs to provide increased services to non-residential clients.

Finding: Law Enforcement, DFCS, Doctor's offices, Health Dept. etc. run out of brochures or handouts to give to victims with crisis line numbers and resource information.

Recommendation: Domestic violence agencies should share a template with all the agencies so they can print their own. If this is not possible, assign one person in the agency the responsibility of making sure all the agencies have materials on a regular basis and put a contact number to get more brochures on display cases.

Legal Response Findings and Recommendations

DEBORAH CUADRA, AGE 45, WAS SHOT BY HER HUSBAND THREE MONTHS AFTER FILING FOR A TPO.

Department of Corrections (DCOR)

Finding: There is a need for increased communication between District Attorneys' offices and prison officials.

Recommendation: Create a project to increase collaboration and information sharing on the state level between District Attorneys' offices and prison officials.

Finding: DCOR's website does not offer enough information on prisoners or ex-convicts regarding their crimes. Furthermore, information on a prisoner's status and changes to their status should be available to the public in a timely manner.

Recommendation:

1. DCOR should add information on their website offering viewers not only what crime was committed by the perpetrator, but indicating if it was stranger or intimate partner violence. It was discovered in one review that a friend of the homicide victim heard about the perpetrator having had a criminal history. The friend looked the perpetrator up on DCOR's web site. The site offered the friend the crime of aggravated assault but did not give the relationship of the victim to the perpetrator. It is not necessary to disclose the victim's private information to be able to give inquirers information that could make a difference. The homicide victim was told by the perpetrator that he had assaulted a girlfriend's old boyfriend that tried to hurt his girlfriend. In fact, the perpetrator had almost killed another woman that was trying to break up with him after only dating her for two weeks. He assaulted her in the same manner in which he eventually killed his next victim.
2. All victims of crime should be notified by DCOR when the offender's prison status changes. The information for VINE should be added to all domestic violence information that is being created in all the different systems.
3. Information on a prisoner's status and changes to their status should be available to the public in a timely manner, including date of last update.

EMS

Finding: Police reports do not include basic information regarding EMS personnel badge numbers, names etc. often because of an unspoken agreement between the entities. However, this information could provide powerful testimony in some domestic violence cases.

Recommendation: Policy and procedures should be adhered to when collecting information and writing a police report. EMS should be subpoenaed to testify when their knowledge in the case could benefit prosecution, and their reports should be incorporated or noted in police reports to let prosecutors know they are available.

Finding: EMS reports are often not detailed regarding communication with the victim. However, a victim may open up to an EMS worker because they may view them as less intimidating than a law enforcement officer.

Recommendations:

1. EMS workers submit more detailed reports regarding victim's appearance, quotes etc. that would assist in describing the scene.
2. EMS workers receive regular training on domestic violence, safety planning and lethality assessments.

Family Violence Intervention Programs (FVIPs) for Abusers

Finding: FVIPs do not consistently communicate with the victim liaisons regarding the initial screening of the perpetrator.

Recommendation: FVIPs should be required through certification to communicate with the victim liaison regarding the perpetrator's initial screening outcomes. This information will assist the liaison in developing a customized safety plan for the victim.

Finding: 40% of the perpetrators in reviewed cases had prior suicidal ideation, 28% completed suicide and 4% attempted suicide.

Recommendations:

1. An FVIP's screening tool should include several questions about suicide that are detailed and open-ended. If the perpetrator admits suicidal thoughts/threats or attempts the FVIP should contact the victim liaison immediately.
2. Victim Liaisons should receive on-going and current information and training regarding lethality indicators, safety planning and the laws of the state.

Finding: FVIPs sometimes rely on batterers for information during their enrollment without communicating with enough other collateral sources regarding any past or present violent behavior.

Recommendations:

1. Victim Liaisons provide a source of information to assist FVIPs in holding batterers accountable for their actions. For example, victim liaisons should be trained to conduct a lethality assessment with each victim and this information should be shared with FVIP providers in a way that does not breach the confidentiality of the victim.
2. FVIP providers and Probation officers need to have policy regarding information sharing and they need to communicate closely with each other. FVIP providers and Probation officers should include in their assessment detailed questions regarding suicide and homicide threats by the perpetrator.

Finding: In some communities, there is a lack of communication between the FVIP's community based victim liaison and the court based Victim Witness Advocate.

Recommendations:

1. Collaboration between these two professionals is valuable for follow-up advocacy with domestic violence victims and should occur in every community.
2. The Victim/Witness Advocate should provide the victim liaison with victim contact information for continuing advocacy after the case has been prosecuted.
   (See Counseling and Mental Health Services, and Drug & Alcohol Treatment Facilities Sections and www.dcor.state.ga.us for complete listing of certified FVIPs.)

GCIC

Finding: GCIC criminal histories are sometimes not complete, or at times they are incompletely entered, regarding criminal history information, making the setting of bonds difficult for judges and creating incomplete pictures for prosecutors.

Recommendations:

1. GCIC experts should be invited to local domestic violence task forces.
2. GCIC should identify how errors are occurring and develop a training strategy to address this.

Guns

Finding: There is a lack of consistency of Judges ordering firearm removal for TPOs, sentencing, or as a condition of probation. Furthermore, when perpetrators are offered diversion through the prosecutor's office, they cannot be held accountable for their firearm possession.

Recommendations:

1. Judges should consistently order the removal of firearms, as required by federal law, as well as carrying permits, and should include orders to law enforcement directing the removal.
2. Probation officers should be allowed to conduct a thorough search of a probationer's home to look for firearms.
3. Anyone reporting that a perpetrator is in possession of a firearm after having had an order for removal should have the ability to report anonymously.
4. Diversion should typically not be granted in family violence cases.

Finding: Shotgun purchases do not have the same licensing requirements as handguns and other firearms.

Recommendation: Shotgun purchases should have the same licensing requirements as handguns and other firearms.

Finding: The policy/procedure for collecting the guns when a Judge has ordered that the weapons be removed is unclear as far as who is responsible for collecting them, what follow-up is to be done, and where they are to be stored.

Finding: Also, far too often perpetrators are asked to surrender any firearms and then the guns are given over to family members of the perpetrator, either by the asking entity or by the perpetrator.

Recommendations:

1. The ordering Judge may state on the record as to how the guns are to be collected and stored.
2. Firearms retrieved from a domestic violence perpetrator should not be handed over to family members of said perpetrator.

Judicial

Finding: Procedures developed to expedite bond hearings and give perpetrators the ability to be released from jail without going before a judge place domestic violence victims in great danger, and they do not adhere to state law for victim notification. These expedited dockets often leave judges without any information regarding perpetrators' prior criminal histories or prior TPOs at the time of the bond hearings. Furthermore, there is not enough time to notify the victim of any conditions of bond or to provide notification of victims' rights as required by law, thereby leaving the victim unprepared for when a perpetrator quickly returns home in both scenarios.

Recommendation:

1. Docketing should be structured in a way that permits the opportunity and time for advocates to contact and safety plan with the victims.
2. Domestic violence perpetrators should not be allowed to bond out of jail without first seeing a Judge. Special Conditions of bond should be considered for all domestic violence cases.
3. While many of the task forces had different methods to get to this recommendation, all were in agreement that trials should be expedited so as to better serve victims and to better hold perpetrators accountable soon after the offense.
   (See Legislation Section)

Finding: Judges do not have access to the criminal and civil histories of the offenders at the bench or before bond hearings.

Recommendation:

1. Judges should have access to a perpetrator's entire criminal history when making decisions about cases.
2. Create a position in the Magistrate Courts that collects all the information on the perpetrator, i.e., TPO Registry, prior 911 calls to home, criminal history etc. from all the different people that already have this information.

Finding: Judges are not participating on all domestic violence task forces or the fatality review committees across the state.

Recommendation: Judges should participate in task forces and fatality review teams, as permitted and anticipated by the JQC's opinion about the ethics of such participation. The JQC issued Opinion No. 201 in response to the question of judicial participation on domestic violence task forces. It states, "As a judicial officer and person specially learned in the law, a judge is in a unique position to contribute to the improvement of the law, the legal system, and the administration of justice, including revision of substantive and procedural law and improvement of criminal and juvenile justice. To the extent that time permits, judges are encouraged to do so, either independently or through a bar association, judicial conference, or other organization dedicated to the improvement of the law."

Finding: Judges are not consistently mandating perpetrators to state certified FVIPs for a variety of reasons including cost of the programs, diversion programs, and reliance on anger management programs. Also, judges are offering diversion programs to both the perpetrator and the victim after a dual arrest has been made.

Recommendation: Judges should consistently order family violence perpetrators to FVIPs as provided by O.C.G.A. 19-13-10 through 19-13-16, in addition to any other sanction normally imposed. Most family violence cases should not be diverted unless evidence problems prevent prosecution. In cases where diversion is deemed necessary, perpetrators should be referred to a certified FVIP, not anger management.

Finding: At times judges are relying on the victim and the perpetrator to work out child visitation on their own—which allows for the perpetrator to continue exercising power and control over the victim, endangering the victim and the children.

Recommendation: The judge should decide on specifics relating to visitation after taking into consideration the complete information on the case, the perpetrator's history of domestic violence, and any safety concerns of the victim.

Finding: When Judges order a Respondent in a TPO case to attend a FVIP, there is not a mechanism in place to verify the completion of the program.

Recommendation: Circuits throughout the state have come together, usually within their local task forces, to design a solution that fits them locally. A coordinated community response is needed to see this effort through.

Finding: Magistrate court judges are not always available to sign warrants.

Recommendation: Magistrate court judges should be on call 24 hours a day to sign warrants. They should also be provided with a staff person who can assist with that.

Finding: Domestic violence victims are in Magistrate courts filing for warrants without any assistance to navigate the court system.

Recommendation: Advocates should be placed in all Magistrate Courts to assist domestic violence victims with filing warrants. Advocates can assist victims with safety planning, lethality assessments, information on what to anticipate with the system, and in connecting them with direct services such as shelters.

Finding: Some Judicial Circuits are experiencing long wait times for warrant hearings.

Recommendation: A system audit can help identify where in the process things can be simplified; courts should expedite domestic violence cases due to the danger for escalated violence and homicide.

Finding: When a victim attempts to take a warrant out on the perpetrator, there are some Magistrate Courts that send letters to notify the perpetrator of said action even if the request was denied.

Recommendation: Magistrate Courts should reconsider the method of warning and notification of warrant applications while still adhering to state and federal laws.

Finding: Victims often do not know the difference between a bond condition and a TPO.

Recommendation: Judges, Officers and VWAPs should explain the differences to victims and place the information in a printed brochure along with other judicial procedures in an accessible location.

Finding: Some judges are concerned that TPOs are being used by non-victims to improve one's stance during a divorce.

Recommendation: The TPO process and the divorce process should be considered separately by the courts. Judges can look at the two proceedings as two separate cases serving two separate needs.

BREANNA MOSES FUNDERBURK, AGE 24, WAS STRANGLED BY HER ESTRANGED HUSBAND ONE WEEK BEFORE HER 25TH BIRTHDAY.

Law Enforcement

Finding: Law enforcement may be reluctant to arrest someone they perceive as having mental health problems, i.e., suicidal threats.

Recommendation: Regular training for law enforcement on domestic violence and on lethality indicators, including threats of suicide, should be mandated.

Finding: Law enforcement officers do not consistently have the capability to run a criminal history in their vehicles even if they have the resource of a car computer. GCIC requires strict codes regarding access and security of GCIC files and officer's vehicles are not considered secure enough for access. Access of information can be sought through 911 operators but officers report having difficulty getting the information due to lack of time and high call volume for the operators. Law Enforcement officers have said that having information about active parole/probation, prior arrests, prior 911 calls, prior violent offenses or use of weapons, no contact conditions of bond, and the TPO registry before answering a call would increase the preparedness and safety of the officer and help to fully understand the victim's position.

Recommendation: GCIC should consider giving access to officers' vehicle computers so as to better prepare officers for their encounters with perpetrators as they respond to calls.

Finding: Officers do not consistently record children's names on police reports or incident reports because of being concerned of breaking the minor's confidentiality.

Recommendation: Children's names should be included in all reports. Accurate and efficient reports can mean the difference between a weak or strong case in prosecution. Officers can attach an extra page marked, "for law enforcement only" if this information is considered confidential.

Finding: When a responding officer directs a victim to the court to take his or her own warrant, this unnecessarily places the burden of prosecution on the victim.

Recommendation:

1. When law enforcement officers respond to a domestic violence call and find probable cause, they should be taking the warrants themselves. Victims of domestic violence should not be directed to take their own warrants.
2. Law enforcement first responders are often a victim's first contact with the system. It is crucial for law enforcement officers to make appropriate referrals and appropriate arrests. This will have an impact on the victim's willingness to call the police or involve another system in the future.

Finding: While increased police training is valuable, it is believed that there is a gap between protocol and practice. New officers entering the field are sometimes trained on domestic violence protocol and then retrained by their field training officers to handle domestic violence cases in a different way other than protocol.

Recommendations:

1. Law Enforcement agencies should develop special domestic violence units within their offices. Specialized officers dedicated specifically to domestic violence investigation are needed, as well as an advocate within the system to work with victims and their children. In larger jurisdictions, specialized units should be created.
2. Superior Officers should make domestic violence a priority for their departments just as they have with drugs and alcohol. Domestic violence should be considered a zero tolerance issue by law enforcement.
3. Police departments should consider formal systems audits of their responses to domestic violence calls. The process should include follow up with the Chief and supervisors with results. (System audits can be formal processes, but can also include taking a random sample of the previous day's calls for service, approximately 10%; having someone follow up with the victims to ensure victims' satisfaction; and following up with officers where no arrest is made, dual arrest is made, or if no report is written. In cases of no report, officers should be dispatched again to complete the process.)

Finding: Responding officers have at times threatened domestic violence victims by telling them their kids will be taken away, or that if she calls the police one more time they both will go to jail. Victims who have received these threats may be reluctant to call law enforcement for help again. These tactics are not effective in reducing domestic violence.

Recommendation: Officers should refrain from threatening arrest and removal of children to DFCS. Officers should follow protocol when responding to a domestic violence call and supervising officers should regularly monitor for compliance with protocol and policy.

Finding: Some communities are experiencing a dangerous lag time between the issuance of a TPO and personal service upon the Respondent.

Recommendation: Create and sustain a specialized domestic violence unit to serve TPOs and execute outstanding domestic violence warrants.

Finding: Law enforcement officers don't always separate the two parties to conduct private, individual interviews with each party when responding to a domestic violence call.

Recommendation: Protocol and policy should be followed so that all parties involved will have a private interview. Victims should be removed from earshot or eyesight of the perpetrator before the interview begins.

Finding: Law enforcement runs out of, or never had, brochures or handouts to give to domestic violence victims at a scene.

Recommendations: All law enforcement officers who respond to domestic violence calls should have in their vehicles at all times a handout with information on resources for victims of domestic violence.
(See Legislation and Municipal Sections)

Municipals

Finding: At times, Law Enforcement officers arrest perpetrators with citations that are not required to be bound over to state court—for example a disorderly conduct charge. The negative consequences of law enforcement and municipals charging crimes in this manner are abundant. Two of the most important consequences are that perpetrators are not held accountable for their violent crimes through proper criminal charges and their victims are not given the opportunity to talk to someone who could help them break free of the violence or offer support and safety planning. Also, the state prosecutor does not have access to the disorderly conduct citations or arrests on the GCIC. Finally, prior convictions under municipal citations can prevent the enhancement provisions from being enacted in repeat violations of the family violence law.

Recommendation: Law Enforcement officers should make it a priority to ensure that domestic violence cases are charged and filed under the Family Violence Act which in turn allows for an enhancable offense.

Finding: The manner in which perpetrator's arrest records are kept varies from municipal to municipal placing it on a spectrum of difficult to almost impossible for investigators to retrieve for prosecution of other charges and homicide investigations. The report forms vary also. The state has a form for law enforcement specifically designed for family violence act charges. However, it is not state mandated so police departments, county police departments and sheriff's offices all over the state use a large variety of forms.

Recommendation: All departments should use the state forms for family violence offenses. (See Law Enforcement Section)

JENNIFER L. COLE, AGE 44, WAS BEATEN AND STABBED OVER 100 TIMES AND BY HER HUSBAND.

911 Operators

Finding: Operators are not consistently trained regarding domestic violence nor do many participate on local domestic violence task forces.

Recommendations:

1. Operators should receive annual, required training on domestic violence, safety planning with victims and lethality indicators.
2. 911 operators and supervisors should participate regularly on their local domestic violence task forces as well as the Fatality Review Committees. Task forces should make it a priority to invite 911 personnel to the table.

Finding: Some 911 Operators do not have access to warrants and are unable to inform responding officers to a domestic violence call regarding special conditions of bond.

Recommendation: Make warrants electronically accessible to law enforcement through computers in their vehicles and to 911 operators at the call center.

Finding: 911 tapes are periodically recycled often making it impossible for law enforcement or prosecutors to pull the tapes as evidence.

Recommendation: 911 should develop a different procedure regarding 911 calls that report violent crimes to ensure that those tapes are accessible by the time the case goes to trial, which is often many months later.

Pardons and Parole

Finding: When perpetrators make a plea agreement with prosecutors there is often not a pre-sentencing investigation by Pardons and Parole.

Recommendation: A pre-sentencing investigation should occur when perpetrators plead out to lesser charges. This will provide a better understanding of the circumstances surrounding the crime, the perpetrator and victim(s) involved. It is also important to have similar priors and information in the prisoner's file for Pardons and Parole to take in consideration when dealing with parole hearings.

Finding: DCOR does not consistently notify the prosecutors' offices in a timely manner when releasing parolees. This prevents prosecutors from notifying victim(s) or any witness(es) who, by state law, have the right to be notified and whose safety is impacted by release and notification.

Recommendation: DCOR should make it a priority to improve the system of release notification.

Finding: At least eight of the perpetrators of homicide were convicted felons who committed murder after their release from prison. At least one perpetrator was given an early release, after which he committed a homicide, with a method similar to earlier attacks on other women.

Recommendation: Domestic violence offenders should not generally be considered good candidates for early release. Any such offender being considered for early release should undergo a thorough psychological examination and a lethality assessment.

Private Attorneys

Finding: In civil proceedings, attorneys are reluctant to address the issue of domestic violence.

Finding: When parties have two pending civil cases, such as a TPO and a divorce, the cases might be combined rather than being handled separately. The blending of TPOs and divorces often overlooks the safety issues of the victim. Not only is the protective language of the TPO omitted from the final decree, it may appear as though the victim has dismissed the TPO. When cases are entered together, attorneys have the ability to manipulate the conditions of both cases, sometimes in a manner which creates contradictions between orders. The victim is left without a certified copy of the TPO to show law enforcement in the event that she has to call them to report a violation. When TPO's are erased by this process, the victim loses the ability to engage the criminal justice system when the TPO is violated since breaking conditions of a divorce remains a civil matter. Furthermore, without a separate TPO, nothing is added into the TPO Registry about the offender.

Recommendations:

1. Provide domestic violence training to private attorneys specifically regarding safety concerns for domestic violence victims. This training should include information on high lethality indicators.
2. Approach the local bar association about providing training for private attorneys where they can receive continuing education credits.
3. Avoid having TPOs absorbed into divorce decrees.

Probation

Finding: Perpetrators who test positive for drugs or alcohol during probation will face consequences from the Probation Officer (PO) but often the PO does not bring the positive tests to the judge's attention.

Recommendation: If a perpetrator tests positive for drug and alcohol, POs should report to the judge immediately so the judge can include treatment into probation sentencing. This creates more accountability and puts the violation on court record along with the specific orders from the judge.

Finding: Victims, Victim Liaisons and FVIP providers are not made aware of sentencing requirements, i.e., stay away conditions or no violent contact conditions from the judge as Probation Officers keep their records confidential.

Recommendation: Probation officers should share with the FVIP provider the conditions of sentencing. If probation officers are prohibited from sharing the sentencing sheet with the FVIP, perpetrators should be required to sign a release form agreeing to share any conditions that the judge has set with the FVIP, the victim liaison and the victim.

Finding: It is not clear who carries the burden of proof for probation violations, i.e., a probation officer witnesses bruises on a probationer's victim. Also, victims are informed and instructed that they must document and present violations to a probation officer in order to get probation revoked. This can all occur when a probationer is on probation for a family violence offense or for another unrelated offense.

Recommendations:

1. Probation officers, state or private, should keep victims' safety as a top priority at all times. If a probation officer cannot place the perpetrator under arrest immediately upon seeing the victim's injuries and taking her statement, then the burden of proof should not solely be placed upon the victim. Probation Officers can collect evidence-- i.e., taking pictures of the injuries and damaged property etc., and can then call local law enforcement to the scene so they can take action against the perpetrator. If the victim is not cooperative with the probation officer, that officer is still obligated by ethics and law to follow procedures and take action when probable cause is established.
2. Develop units within probation offices/companies comprised of probation officers who deal only with domestic violence perpetrators. These specialized officers can reach out to the community through task forces, FVIPs, victim liaisons, VWAPs, shelter advocates and legal advocates resulting in a collaborative community response. Although initially this may appear to create more work for probation officers, it will actually reduce repeat offenses in the long run.

Finding: There is growing concern across the state regarding private probation companies not applying for revocation warrants/hearings specifically with domestic violence perpetrators. Several reasons were cited. One is that private probation companies cannot easily take out arrest warrants due to the employees not being POST certified. The fatality committees speculated that perhaps since private probation is a for-profit company that collecting fines and probation fees are considered more important than holding perpetrators accountable (please see below*). If the perpetrator is in jail for violation of probation the fees will no longer be paid.

* Note: There was a lack of representation of private probation companies on the fatality review committees. When private probation was at the table, they were extremely active on the task forces. The communities that had active participation from private probation companies did not voice concern regarding the revocations. These private companies worked closely with the judges and other systems for accountability of operations and collaborative community response.

Recommendation: Local governments should go back to running misdemeanor probation.

Prosecutors

Finding: Prosecutors are not consistently using the Family Violence Act to charge cases where a violent crime has been committed against a spouse, live-in partner, or family member.

Recommendation: All family violence crimes should be prosecuted according to the statute defining them.

Finding: Prosecutors are sometimes placing cases on a "hold" in order to make deals with criminal defense attorneys in which the charges are dismissed upon the defendant's completion of a class, such as parenting, drug and alcohol 12 step programs, anger management classes, or an FVIP. If the defendant completes the conditions of the agreement, the case will not be prosecuted and subsequently will appear on a perpetrator's criminal record as a dismissed case.

Recommendation: Holding and eventually dismissing cases only serves to lessen perpetrator accountability, thereby decreasing victim safety.

Finding: Judges and Prosecutors are sometimes offering perpetrators diversion versus being prosecuted for the crime. Diversion varies greatly from having to attend a one-time three hour class, to parenting classes, to twelve-step programs, to anger management, to FVIPs. If the perpetrator adheres to the court order of diversion, then the charge(s) will be dismissed after a period of time determined by the prosecutor. Diverted cases remove the ability of future prosecutors to file enhanced felonies based on prior cases. Note: It is important to recognize that not all courts that offer diversion for crimes, offer diversion to domestic violence perpetrators.

Recommendation: Family violence cases where there is strong evidence of a crime should never be diverted.

Finding: Prosecutors allow perpetrators to plead out, or to plead to a lesser charge (such as disorderly conduct) in order not to go to trial. However, misdemeanor domestic violence offenses provide a critical point of intervention for victim safety and offender accountability. Tougher prosecution and victim centered advocacy can provide an opportunity for homicide prevention.

Recommendation: Prosecutor's offices need to utilize a consistent procedure for handling domestic violence cases which promotes aggressive prosecution when evidence supports it.

Finding: There is a need for more detailed information to be given to the prison officials from the DA's Office for the perpetrator's files in prison.

Recommendation: A specific project should be created focusing on the communication needs between DA's Offices and prison officials to create a better flow of communication and openness between the two systems. (See DCOR section)

HELEN JONES RICHARDSON, AGE 41, WAS SUFFOCATED AND BEATEN TO DEATH BY HER BOYFRIEND.

TPO Registry

Finding: Not all counties are using the standardized statewide TPO forms. This creates problems when entering orders in the TPO Registry.

Recommendation: Task forces should advocate for the use of standardized TPO forms in their community.

Victim/Witness Advocate Program (VWAP):

Finding: VWAPs are frequently the first advocates that domestic violence victims come in contact with.

Recommendations:
1. It is vital that VWAPs do lethality assessments and individualized safety planning with victims as well as offering them more resources.
2. VWAPs should attend regular training on domestic violence.
3. VWAPs should give prosecutors the lethality assessments, within the ethics of confidentiality, so as to provide more information about the domestic violence case at hand.

Finding: There are prosecutors' offices in Georgia that do not have a specialized domestic violence unit.

Recommendation: Develop specialized domestic violence units within prosecutors' offices where there is a substantial caseload.

Finding: The definition of family violence is broad in the law, so as to encompass a variety of relationships. However the power and control dynamics known to exist in intimate partner violence may be different than those reflected in non-intimate partner violence (i.e. two brothers fighting).

Recommendation: VWAPs concentrate on cases where power and control is present in intimate partner relationships.

Transforming Communities

The participating communities were brave for participating in this first year, but they were also transformed. They shared their fears about entering into the Fatality Review process and talked about the things their community was able to accomplish through it. Their thoughts are shared here, to help communities considering Fatality Review get some insight into how this process can transform the community.

The fears community members experienced:

…that we would not look at systems changes that needed to occur, but rather point fingers
…that there would be blame placed, instead of looking at how we could improve
…that it would be another committee that did not produce results
…people would be resistant to sharing
…that a special interest group would take over the process
…that the victim would be blamed for her own death

What we learned by doing Fatality Review:

"I better understand the holes in the safety net and the need for better collaboration between systems, and the need for more public awareness."

"I have learned that the more we work together as a team, the more we can accomplish."

"It showed that there are breakdowns within our criminal justice and educational systems."

What has been created by Fatality Review that would otherwise not come about:

"Without this process we would be working on other goals that would not be as relevant to addressing domestic violence in our community."

"The process gave us the ability to step back and review cases from a wider perspective, not just one system's myopic view."

"The work we did through the Fatality Review Team provided an opportunity to examine real responses in our community, and in that learning process it has provided both general and specific ways we could recommend change in the community response to domestic violence."

"I was impressed by the quality of the ideas thrown around at the meeting."

"We have set our 2005 goals for the task force from the fatality review recommendations."

A Look Ahead

Fatality Review is an on-going process. Communities which have committed to it continue to learn new and more complex aspects of the system of response for victims and offenders. In 2005, the Georgia Fatality Review Project will continue and add 4 new communities: Hart County, Douglas County, Fayette County and Dougherty County.

As the work continues, we will build on the findings of many review teams that there were more community systems needed at the table. Police 911 dispatchers, EMS workers, health care workers, judges, prosecutors, and others were not present in all the teams, and their input was missed. In the second year, we'll focus on including more people on review teams who respond to families experiencing domestic violence.

An additional focus will be in supporting task forces to develop strategies to implement recommendations. It is hard work to review cases and analyze places where response could be better. Even more difficult perhaps, is developing ways to change practices so that collaboration increases, holes in the safety net are closed, and victims experience greater safety.

Data analysis will be more systematic in the second year. We found in many reviews, data was missing. With one year of experience, we will work with an eye to getting uniform data on some factors for all cases reviewed.

Finally, our project will tackle the question of how small rural communities, which may not experience domestic violence homicides ever year, can benefit from this project. A number of strategies will be explored, including merged teams or special one-time review panels, to give more rural communities the opportunity to experience the process and benefits of Fatality Review.