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Georgia Fatality Review Project

Annual Report 2005

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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 continue to make 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 second year has been a success.

Fatality Review Project Staff

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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 (800-33-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 Victim Liaison 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 domestic violence task forces in judicial circuits and to monitor legislation impacting families experiencing domestic violence. GCFV is the certifying body for Family Violence Intervention Programs (FVIPs) in Georgia and provides training and technical assistance to FVIPs and task forces, and hosts an annual state-wide conference on domestic violence.

Special Thanks

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Fatality Review Project Advisory Committee

Many thanks are due to our Fatality Review Project Advisory Committee, whose leadership and time dedication have helped to provide ongoing direction for this project. The members of the Advisory Committee include:

Ms. Jamie Apple-Anderson on behalf of
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Review Teams

We acknowledge the commitment of the Fatality Review participants from around the state who devoted their time, energy and expertise to work towards creating safer communities.

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Ramona Wilson, DeKalb County District Attorney's Office
Arin Zerden, DeKalb County District Attorney's Office

"Never doubt that a small group of thoughtful committed citizens can change the world. Indeed, it's the only thing that ever has."

–Margaret Mead

2004 DOMESTIC VIOLENCE DEATHS IN GEORGIA

County	# of Primary Victims	# of Secondary Victims	# of Alleged Perpetrators	2004 Total Deaths	2003 Total Deaths
Barrow	1			1	1
Bartow					4
Ben Hill	1		1	2	1
Bibb	2		2	4	1
Brantley	1			1	
Burke	1			1	2
Butts					1
Calhoun					3
Camden		1		1	1
Carroll	1			1	1
Chatham	2			2	6
Cherokee	1			1	1
Clarke					3
Clayton	2			2	3
Cobb	3			3	6
Colquitt					3
Columbia					1
Crisp					2
DeKalb	3	1		4	17
Dooly	1			1	
Dougherty		1	1	2	1
Douglas			1	1	1
Elbert					1
Fannin					1
Fayette	2		2	4	
Floyd	2			2	1
Forsyth					4
Franklin	1			1	
Fulton	9	3	2	14	10
Glynn					2
Gordon		4		4	
Grady					1
Gwinnett	10		2	12	6
Habersham					1
Hall	1			1	
Hancock	1			1	
Haralson					4
Harris	1			1	
Henry		1		1	3
Houston				1	1
Jackson	1		1	2	
Jefferson					2
Johnson			1	1	
Laurens	1		1	2	2
Liberty					4
Lowndes	1			1	
Lumpkin	1			1	1
Madison					2
McDuffie	1		1	2	1
Montgomery					1
Muscogee					3
Newnan	1			1	
Newton	1			1	3
Oconee	1			1	
Oglethorpe					1
Paulding	1		1	2	1
Polk	1		1	2	1
Richmond	4		2	6	4
Rockdale	1	2	1	4	
Tattnall	1		1	2	1
Thomas	1			1	
Towns	1		1	2	
Troup					1
Twiggs	1			1	
Undisclosed					3
Upson	1			1	2
Walton	2			2	
Washington					1
Wayne					4
Webster					1
Wheeler					1
White	1			1	2
Whitfield	2		1	3	2
			Total	107	137

2004 CAUSE OF DEATH

74 Gunshots

20 Stabbings

3 Strangulations

9 Other Objects/ Unknown

TOTAL: 107

2003 CAUSE OF DEATH

101 Gunshots

15 Stabbings

1 Head Injury

7 Strangulations

5 Beatings

1 Hanging

1 Pushed from Car

2 Arson

1 Asphyxiation

3 Unknown

TOTAL: 137

Executive Summary

Overview

In 2004, 107 people died in Georgia as a result of domestic violence.[1] The majority of those 107 deaths represent individuals killed by an intimate partner, but the number also includes children, parents, and friends of those victims – and sometimes even the perpetrators themselves – who also died in the course of these homicides. For the friends, families, and loved ones of the deceased, the impact of this profound loss is undeniable. Yet these acts of violence reach even farther, causing individuals and communities to examine the problem of domestic violence and their role in preventing such tragedies.

This year's Fatality Review Project examines nineteen of these homicides in depth as a means of reaching a deeper understanding of this tragic loss of life. This is the second Annual Report of Georgia's Fatality Review Project. Like the first report, it tells the stories of individual victims while also finding trends in the aggregate data. Ultimately, the report concludes with recommendations for change in policies and practices across a range of systems designed to help reduce the number of domestic violence-related deaths and injuries.

The Project is primarily federally funded by the Violence Against Women Act (VAWA) and through Georgia's Criminal Justice Coordinating Council. It is conducted jointly by the Georgia Coalition Against Domestic Violence (GCADV) and the Georgia Commission on Family Violence (GCFV). Two full-time Fatality Review Project Coordinators led and assisted Fatality Review Committees from across the state in conducting these fatality reviews. The Fatality Review Advisory Committee, consisting of leaders from various systems across the state, continues to meet to provide support and direction to the project.

Mission Statement

The Georgia Fatality Review Project seeks to enhance the safety of victims and the accountability of batterers. The project does this by conducting detailed reviews of fatalities and by preparing, publishing, and disseminating objective information gained from these reviews. The resulting information is used 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 providing a forum for increasing communication and collaboration among those involved in a coordinated community response to domestic violence.

General Findings

Of the 19 cases reviewed, there were a total of 26 fatalities. These included:

- 19 intimate partner victims
- 4 alleged perpetrators
- 2 children of the intimate partner victim
- 1 new partner of the intimate partner victim.

Of the 19 intimate partner fatalities,

- 11 deaths were caused by firearms
- 6 deaths were caused by stabbing or laceration
- 1 death was caused by strangulation
- 1 death was caused by asphyxiation due to smoke inhalation.

[1] *Statistics compiled by the Georgia Coalition Against Domestic Violence from its clipping service and from reporting domestic violence programs statewide. This count represents all the homicides known to us at the time of this report.*

Significant Findings

Many of the significant findings of this year's Fatality Review Project echo findings from 2004.[2] As these patterns begin to develop, the findings take on additional significance. Here are some of the most compelling findings from this year's reviews:

Employment

74% of the intimate partner victims were employed outside the home at the time of the homicide, the great majority of them in full-time jobs. This high rate of employment suggests that employers and coworkers are an important target audience for collaboration, training, and education, as they are well positioned to play a role in homicide prevention. For more information on how employers can best respond, see *The Workplace Responds to Domestic Violence: A Resource Guide for Employers, Unions, and Advocates* by the Family Violence Prevention Fund.

Life Movement and Degrees of Separation

In almost all of the reviewed cases, victims had taken steps toward independence just prior to the homicide that indicated an increasing desire to separate from their batterers – whether filing for divorce, considering relocation for a job, or changing the locks on her residence. These findings about life movement have implications for advocates and others responsible for safety planning with domestic violence victims; namely, that all steps toward independence should be considered in terms of their potential safety implications. Throughout the "Findings and Recommendations" section, you will see a number of vignettes that detail victims' attempts at getting safe.

Visible Injury

In 83% of the cases, no visible injuries were documented by law enforcement prior to the homicide. This finding suggests the need for a critical awareness on the part of law enforcement, courts, and service providers that assessment of risk for lethality cannot rest solely on the level of prior injury to the victim.

Friends and Family

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. This finding affirms 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 system that responds to family violence cases have been largely overlooked as a resource for intervention. The findings in these cases indicate that they are a rich potential resource for increasing victim safety and offender accountability, if they can be empowered, informed, and mobilized to act.

Language Accessibility

In several of the reviewed cases, both victims and perpetrators had difficulty with the English language, and Fatality Review Committees noted consequences for safety as a result. In each of these cases, the perpetrator's grasp of English slightly exceeded his victim's. Only one of these perpetrators had limited conversational English skills; the others relied on interpreters at trial. This finding highlights the necessity of language accessibility within courts, service providers, and all other systems that have contact with victims and batterers. Being served with a protective order in English, for example, will likely have little effect on the behavior of a batterer who cannot read it.

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[2] *Significant findings from 2004: 68% of the intimate partner victims and 60% of the perpetrators were employed outside the home; over 40% of the 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; in 43% of the cases, the victim did not have injuries during prior calls to the police.*

Children Witnessing Homicides; Children Losing their Parents

Minor children were present at 42% of these homicides. Of all the minor children living with the victims at the time of the victim's death, 56% were ten years old or younger. The implications of these findings are twofold. First, domestic violence homicides more often than not cause very young children to lose parents – often their primary caregiver. If the perpetrator had been a secondary caregiver, children often lose that person as well, whether to jail or to suicide. Second, it is often the case that domestic homicides are witnessed by minor children. Given these realities, resources for these children should be abundant, yet our Fatality Review Committees found them instead to be almost nonexistent. One of the Fatality Review Committees has decided to address this problem directly – see the "Transforming Communities" section for more details on their plan.

Prior Contact with Law Enforcement

In 74% of the reviewed fatalities, either the victim or the perpetrator had prior contact with law enforcement in the five years prior to the homicide. This finding highlights the urgent necessity for law enforcement to be well-trained on the issue of domestic violence and skilled at lethality assessment. Likewise, the high rate of prior contact with law enforcement agencies suggests that this system represents a crucial opportunity for intervention before cases become fatal.

Suicide

37% of perpetrators in the reviewed cases were known to have either threatened or attempted suicide prior to the homicide, and 38% attempted or committed suicide at or after the homicide. These findings have implications for everyone who interacts with victims and batterers who would be in a position, upon knowing of a batterer's suicidal ideation, to warn the intimate partner of possible danger and link the batterer to the help he needs.

All of these significant findings, and those that follow in this report, came about through the commitment and perseverance of dedicated individuals across the state who continually strive to end domestic violence. Fatality Reviews have helped communities across Georgia to garner insight, awareness, and momentum in ending domestic violence. Some of these communities have already taken the first steps toward implementing the recommendations they have developed through this process (see the "Transforming Communities" section of this report for more details). This implementation work, one of the most challenging aspects of the Fatality Review process, also brings the greatest hope for lasting change. As a means of bringing about this change, the Fatality Review Project will increasingly focus on implementation.

The cover art represents the Fatality Review Project's significant findings from the last two years that the number of people who can intervene with domestic violence is larger than we originally thought. If we are ever to have an impact on domestic violence and related homicide in our communities, we must engage everyone that has a role to play: hairdressers, school teachers, employers, faith leaders, medical professionals, child care centers and other community members. When we recognize non-traditional systems as our allies and provide them with resources and knowledge, then we truly will begin to succeed in our work to end domestic violence.

METHODOLOGY

Committee Formation

The Domestic Violence Task Force in each participating community was asked to form a multi-disciplinary Fatality Review Committee to function as a sub-committee of the Task Force. Representatives from the following systems comprised the Fatality Review Committees:

- Advocates based in Shelters, Law Enforcement Agencies, and Prosecution Offices
- Private Probation
- State Probation
- County Probation
- Parole
- Judges
- Legal Services
- District Attorneys & Solicitors General
- Department of Family and Children Services
- Family Violence Intervention Programs
- Law Enforcement
- Faith Community
- Animal Control
- Drug and Alcohol Counselors
- Medical Professionals
- School Counselors
- Military Advocates and other personnel

Each Fatality Review Committee sent representatives to a day-and-a-half long Fatality Review Training coordinated by GCADV and GCFV.

Case Selection

After the training, the two coordinators began to work with the Fatality Review Committees to identify anywhere from one to three local domestic violence-related homicides for 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 identifying 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 believed had a significant impact on their community.

Case Information Collection

Once the cases were selected, the committee members gathered all 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 applicable and 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 Coordinators. First, family and friends were identified. Then letters were mailed explaining the fatality review process and the purpose of the project. This letter invited family and friends to contribute information via a telephone interview, an in-person interview, or written communication. They were also given the option to decline participation.

Most family members and friends who participated in interviews did so by phone, although a few chose to meet the coordinators in person. Most discussions went well over an hour and were incredibly emotionally draining for the surviving family members and the interviewers. The discussions were open-ended, where family members and friends shared what they wanted the review team to know about their loved ones, the steps the victims took to try to be safe, and what they wanted them to know about the victim's perceptions of the options available in the community.

Case Chronology Development

After collecting all available information, the Chairperson of the Fatality Review Committee forwarded the case information to the Project Coordinator so that a timeline of the events leading up to the fatality could be developed. The timeline, also called a 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 this victim or another. The focus of the chronology was to identify every opportunity that any segment of the community had to intervene in the escalation of violence. The completed chronology was distributed to committee members for their review. Review participants read the chronology to become familiar with the case and organize their thoughts prior to the review.

Fatality Reviews

The fatality reviews lasted an average of 3-4 hours. After signing a confidentiality agreement, a moment of silence was observed honoring the victim(s), followed by an out-loud reading of the chronology. Then the committees went item by item through the chronology to see where the community could have stepped in – and how the system response could have been stronger. With a strong trust in each other and a commitment not to blame one another, the Fatality Review Committees—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 and offender accountability.

Development and Implementation of Findings and Recommendations

Fatality Review Committees then made findings about the factors in each case which appeared to contribute to the death - or conversely, actions which, if taken, might have prevented the death. Review Committees were always focused on reviewing the system's response – what services were available in that system for victims and offenders, what was the protocol for response, was it followed or not, and what monitoring, training and accountability existed in that system for workers who responded to families experiencing domestic violence. From the findings, each committee 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 fatality review meeting, the Project Coordinators filled in a uniform data tool designed for this project and adapted from the work of data collection tools used around the country. This data was then entered into a database to form the aggregate data that comprises the Data Findings section of this report.

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 of the reviews is unknown and is indicated as such on the charts below. Nineteen cases were reviewed, and the data is organized into the following sections:

Adriana Vigil, 19, recent high school graduate: shot in the face by her husband in the presence of three acquaintances

SECTION 1: DEMOGRAPHIC INFORMATION

Table 1: Demographics	Victim		Perpetrator	
Characteristic	**Number**	**%**	**Number**	**%**
Gender				
Female	18	95%	1	5%
Male	1	5%	18	95%
Age (Mean)	32		37	
Employment Status				
Unemployed	2	11%	6	32%
Unemployed student	0	0%	1	5%
Employed full-time outside the home	12	63%	6	32%
Employed outside the home, unsure if part-time or full-time	2	11%	0	0%
Self-employed	0	0%	1	5%
Unknown	3	16%	5	26%
Sources of Financial Support				
No personal income; reliant on perpetrator for financial support	2	11%	0	0%
No personal income; reliant on victim for financial support	0	0%	6	32%
Personal wages	13	68%	7	37%
SSI / SSDI	1	5%	0	0%
Drug dealing	0	0%	1	5%
Unknown	3	16%	5	26%
Citizenship/Immigration Status				
Citizen of U.S.	16	84%	16	84%
Green Card	1	5%	0	0%
Unknown	2	11%	3	16%
Primary Language				
English	16	84%	16	84%
Spanish	2	11%	2	11%
Portuguese	1	5%	1	5%
TOTAL NUMBER OF CASES REVIEWED	**19**			

Nikita Freeman Jones, 22, mother of three, hospital worker: stabbed and beaten to death by her husband in front of her three small children

SECTION 2: DOMESTIC VIOLENCE FATALITY DATA

Who Was Killed

Of the 19 cases reviewed there were a total of 26 fatalities. This includes:
- 19 Intimate partner victims
- 4 Alleged perpetrators
- 2 Children of the intimate partner victim
- 1 New partner of the intimate partner victim

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

Table 2: Location of Homicides

HOME	BARN	PUBLIC PARK	MOTOR VEHICLE
16	1	1	1

59% of the reviewed homicides occurred in the marital home of the domestic violence victim and perpetrator, 26% of the reviewed homicides occurred in the domestic violence victim's home, and about 15% of the reviewed homicides occurred in other places outside of the home.

HOMICIDE NARRATIVES

This chart briefly describes each homicide reviewed. Sentencing data sources are Prosecutor's files, Georgia Department of Corrections, and Fatality Review Committees. This data represents our best efforts to reflect accurate sentences.

Brief Narratives of Each Fatality	Sentence Imposed for this Homicide
CASE 1: DV perpetrator stalked DV victim after their separation and pressured her to come back to the marital residence to talk. While she was at the residence, the perpetrator shot her in the back with his shotgun and then shot himself in the chest.	CASE 1: Perpetrator survived a self-inflicted gunshot wound. He pled guilty to Voluntary Manslaughter and was sentenced to twenty years in prison.
CASE 2: DV perpetrator shot and killed DV victim and then shot himself. A twelve month protective order had been issued against the perpetrator 4 days prior to the homicide and he had recently been served with divorce papers. DV perpetrator was a convicted felon for domestic violence related charges involving his previous wife.	CASE 2: Deceased perpetrator.
CASE 3: DV perpetrator shot and killed DV victim after they returned home from dinner with her adult daughter. Two weeks earlier she had confided in her co-worker that she was ready to break up with the perpetrator and ask him to move out of her house.	CASE 3: Perpetrator pled guilty to Murder and Possession of a Firearm during a Felony. He was sentenced to life in prison plus five years to run consecutively.
CASE 4: DV perpetrator shot and killed DV victim and her thirteen year old daughter. He then fled to a neighboring state where he shot and killed himself. After a long history of domestic violence, the couple had separated three weeks before the homicide.	CASE 4: Deceased perpetrator.

Helen Rivers, 40, mother of one child, worked in the insurance industry: shot in the chest by her boyfriend

Latashia Robinson, 29, mother of one child, office worker: shot in the face and head by her boyfriend, who then attempted suicide

Brief Narratives of Each Fatality	Sentence Imposed for this Homicide
CASE 5: DV perpetrator laid in wait outside DV victim's residence before shooting and killing her and her boyfriend. The perpetrator and victim's two young children were in the apartment while the murders took place. Approximately eight months earlier the perpetrator was arrested for Aggravated Assault, Cruelty to Children and misdemeanor battery for an incident involving the DV victim.	CASE 5: Perpetrator was found guilty of two counts of Murder and one count of Aggravated Stalking. He was sentenced to life in prison with the possibility of parole.
CASE 6: DV perpetrator stabbed DV victim in the back while her infant granddaughter lay in the bed next to her. DV Perpetrator was a known substance abuser.	CASE 6: Perpetrator pled guilty to Voluntary Manslaughter and was sentenced to twenty years in prison.
CASE 7: DV perpetrator shot DV victim twice in the head before cutting himself in the neck and chest. The parties had extensive involvement with the criminal justice system prior to the homicide.	CASE 7: Perpetrator survived his self-inflicted injuries. He pled guilty to Involuntary Manslaughter and was sentenced to ten years in prison to serve four.
CASE 8: DV perpetrator strangled DV victim to death before setting her body on fire in an effort to cover his crime. The victim's body was discovered in a public park. Approximately three weeks prior to the homicide, the perpetrator had strangled her and threatened to kill her. The red marks on her neck resulting from that incident were witnessed by friends, neighbors, and co-workers.	CASE 8: Perpetrator pled guilty to Murder and was sentenced to life in prison.
CASE 9: DV perpetrator smashed a kitchen glass into DV victim's face and stabbed her multiple times with a kitchen knife. He then slit her throat, and wrote "she lied" in her blood on the kitchen wall, and then wounded himself with the knife. The murder was witnessed by the perpetrator's co-worker. Several of the neighbor's children, including the victim's daughter, played outside during the murder. The perpetrator was a twice convicted felon, once for domestic violence related charges with the same victim.	CASE 9: Perpetrator was convicted of Murder. He was sentenced to life in prison plus five years.
CASE 10: DV perpetrator poured gasoline on DV victim while she was asleep and then set her on fire. The perpetrator was a convicted felon and on supervised probation at the time of the homicide.	CASE 10: Perpetrator was convicted of three counts of Murder, Arson in the 1st degree, Aggravated Assault, and Aggravated Battery. He was sentenced to life in prison.
CASE 11: DV perpetrator gagged the DV victim and cut her throat. The victim was at one time referred to the shelter for assistance. At the time of her death, the victim had a TPO. The perpetrator was a convicted felon.	CASE 11: Perpetrator pled guilty to Felony Murder and was sentenced to life with the possibility of parole.
CASE 12: DV perpetrator shot DV victim in the chest and she then cut his hair. DV victim's mother and stepfather were present at the time of the homicide. The victim and the perpetrator had been arguing the night before due to an alleged affair by the victim.	CASE 12: Perpetrator pled guilty to Voluntary Manslaughter. She was sentenced to ten years incarceration.

Audrey McCormick Pike, 36, mother of four children, retail worker: stabbed in the chest by her daughter's boyfriend, who was hired by her husband to kill her

Elizabeth Ellison, 36, mother of two children, supervisor at a store: shot in the back by her husband, who then attempted to kill himself

continued on next page

Brief Narratives of Each Fatality	Sentence Imposed for this Homicide
CASE 13: DV perpetrator shot DV victim in her head and hid her body in a trashcan. The perpetrator had told her, "you ain't nothing without me."	CASE 13: Perpetrator pled guilty to Murder. He was sentenced to life in prison.
CASE 14: DV perpetrator hired their daughter's boyfriend to kill DV victim. The daughter's boyfriend stabbed the victim 8 times in the chest and neck. The daughter also conspired in the plot to have her mother killed.	CASE 14: DV perpetrator pled guilty to Malice Murder and Felony Murder. He was sentenced to life in prison. The daughter's boyfriend pled guilty to Murder and was sentenced to life in prison with the possibility of parole. The daughter pled guilty to Conspiring to Kill. She was sentenced to ten years with the possibility of parole after completing 1/3 of her sentence.
CASE 15: DV perpetrator shot DV victim in the face once and shot their 2 year-old son twice in the face while their 4 year old daughter watched.	CASE 15: Perpetrator was indicted on 2 counts of Murder and Possession of a Firearm During the Commission of a Crime. After the indictment, he hung himself in his jail cell.
CASE 16: DV perpetrator shot DV victim in the head and then shot himself. At the time of the homicide, the victim had orders in the divorce papers that the perpetrator was to be removed from the home and restrained from threatening or harassing her.	CASE 16: Deceased perpetrator.
CASE 17: DV Perpetrator shot DV victim in the head while she was in bed. The perpetrator was accusing the victim of having an affair and later claimed he put the gun to her head just to scare her.	CASE 17: Perpetrator pled guilty to Voluntary Manslaughter and was sentenced to twenty years in prison.
CASE 18: DV perpetrator stabbed the DV victim in the neck, back, legs, hands, and arms. The victim also received blunt trauma to the abdomen that crushed her liver. Their three young children witnessed the murder. The perpetrator was a convicted felon.	CASE 18: Perpetrator pled guilty to Felony Murder, Aggravated Assault with a deadly weapon, Possession of a Knife during the Commission of a Felony, and three counts of Cruelty to Children 2nd degree. He was sentenced to life with the possibility of parole.
CASE 19: DV perpetrator stabbed the DV victim multiple times. Their 12 year-old daughter was present in the home at the time of the murder.	CASE 19: Perpetrator pled guilty to Murder and was sentenced to life with the possibility of parole.

*** 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.**

Darlene Merritt, 38, mother of two children and a grandmother, worked for the school system: shot by her husband, who then killed himself

Brenda Keller, 41, shot in the face, and her only child, Brittany Cooley, 13, shot in the head: both by Brenda's husband, who later killed himself

Table 3: Types of Homicide

Types of Homicide	Number of Cases	% of Cases
Single victim	11	58%
Homicide / Suicide	2	11%
Homicide / Attempted Suicide	3	16%
Multiple Homicide / Suicide	2	11%
Multiple Homicide	1	5%

Note: Percentages may not sum to exactly 100 percent due to rounding.

Table 4: Cause of Death

Cause of Death	Number of Cases	% of Cases
Gunshot wounds	11	58%
Stab wounds and lacerations	6	32%
Strangulation	1	5%
Asphyxiation due to smoke inhalation	1	5%

Tomeka Baker, 29, mother of two children, retail worker: strangled by her boyfriend, who then burned her body

In over half of the reviewed homicides, gunshot wounds were the cause of death. 32% of the homicides were as a result of stab wounds/lacerations.

Table 5: Who was Present at the Fatality

Present at the time of fatality	# of cases where others were present	% of total cases	Actual number of persons present
Children	8	42%	13
Family members	5	26%	9
Friends	1	5%	1
New intimate partners	1	5%	1
Co-workers	1	5%	1
Witnessed the fatality	# of cases where others witnessed	% of total cases	Actual number of persons who witnessed
Children	7	37%	11
Family Members	1	5%	2
Friends	0	0%	0
New Intimate Partners	0	0%	0
Co-workers	0	0%	0
Killed during the incident	# of cases where others were killed	% of total cases	Actual number of persons killed
Children	2	11%	2
Family Members	0	0%	0
Friends	0	0%	0
New Intimate Partners	1	5%	1
Co-worker	0	0%	0

Anthony Tyrone Scott, 32, father of two children: shot in the chest by his wife in the presence of the wife's mother and stepfather

For the purpose of this table, people who were present at the time of the fatality were in the same area where the homicide occurred, but they did not witness the actual homicide. In 42% of the cases reviewed, minor children were present. In the reviewed cases, 37% of children actually witnessed the murder.

Although this percentage is lower than last year's findings, it still shows a large percentage of children were either present and/or witnessed the murder of their parent. This trend encouraged one community to focus their implementation strategies around this significant finding, which is discussed later in this report. Family members were also present 26% of the time, but only two witnessed the homicide.

SECTION 3: DOMESTIC VIOLENCE PERPETRATORS' HISTORY OF ABUSE AND OTHER LETHALITY FACTORS

Table 6: Perpetrators' History as Known by the Community

Behaviors	Frequency	WHO WAS AWARE? Law Enforcement	Criminal Courts	Civil Courts	Service Providers	Family & Friends
Controlling Behavior						
Isolation of victim	37%	0%	0%	14%	14%	86%
Monitoring and controlling	58%	9%	0%	9%	9%	82%
Ownership of victim	26%	0%	0%	0%	20%	100%
Violent or Criminal Behavior						
Hostage taking	16%	25%	25%	25%	25%	50%
Stalking	26%	40%	20%	0%	20%	60%
Threats to kill primary victim	47%	44%	22%	33%	11%	44%
Threats to kill children, family and/or friends	26%	40%	20%	40%	0%	60%
Strangulation	26%	40%	20%	0%	0%	60%
Harmed victim with weapon	11%	50%	0%	0%	50%	50%
Threats to harm victim with weapon	42%	43%	0%	14%	14%	71%
Inflicted serious injury on victim	11%	0%	0%	0%	50%	100%
History of DV against victim	84%	56%	13%	31%	13%	63%
History of DV against others	37%	57%	14%	14%	0%	71%
Violent criminal history	53%	100%	40%	10%	30%	60%
Child abuse perpetrator	42%	25%	0%	25%	13%	5%
Sexual abuse perpetrator	32%	33%	0%	50%	0%	50%
Mental Health Issues and Substance Abuse						
Depression	37%	29%	29%	14%	43%	43%
Suicide threats and attempts	37%	29%	14%	0%	29%	43%
Alcohol and drug abuse	52%	70%	10%	20%	25%	80%

Kimberly Hart Wilson, 30, stay-at-home mother of one child: stabbed to death by her husband in the presence of the husband's co-worker

Kecia Conley, 20, retail worker: shot in the head by her boyfriend, who concealed her body in a trash can

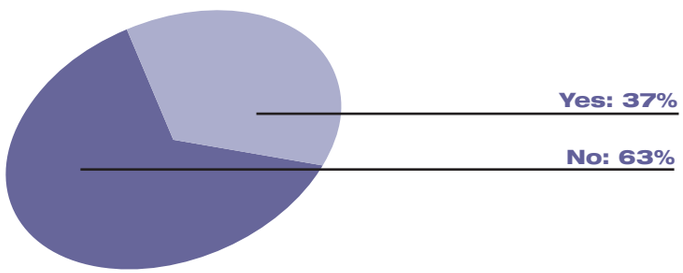
In the 2004 findings, threats to kill the domestic violence victim, threats made with a weapon or firearm, violence in criminal histories, and history of domestic violence were prevalent in over 50% of the cases. The 2005 findings reveal similar patterns: 84% of the domestic violence perpetrators have a history of domestic violence against the domestic violence victim. In addition, over 50% of the perpetrators either abused drugs and alcohol (52%), displayed behavior that monitored and controlled the victim (58%), or had a violent criminal history (53%).

Barbara Owens, 41, mother of two and a grandmother: stabbed to death by her husband in the presence of her infant granddaughter

Who Knew About the Domestic Violence Perpetrator's Behavior?

The sources of information for "Who Knew About the Domestic Violence Perpetrator's Behavior?" were law enforcement, criminal courts, civil courts, service providers, and family and friends. In most of the behaviors illustrated in the chart, family and friends knew more about the domestic violence perpetrator's behavior than the other sources. This finding speaks to family and friends continuing to be the most comprehensive source of information about the victim and perpetrator's situation. Family and friends can be the key interveners and because of this, they play a crucial role in the coordinated community response.

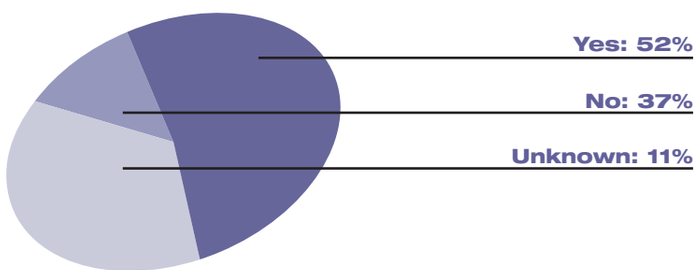
Cases in which perpetrator threatened to commit suicide or made suicide attempts prior to homicide



37% (7 cases) of perpetrators either threatened or attempted suicide prior to the homicide. When those cases where perpetrators attempted or successfully committed suicide at the time of the homicide are included, 47% of the perpetrators — almost half — were suicidal, whether prior to or at the time of the homicide. Family and friends were aware of the perpetrator's suicidal threats or attempts in 43% of the cases where this indicator was noted. Law enforcement and service providers were aware of the perpetrator's suicidal threats or attempts in 29% of the cases where this indicator was noted.

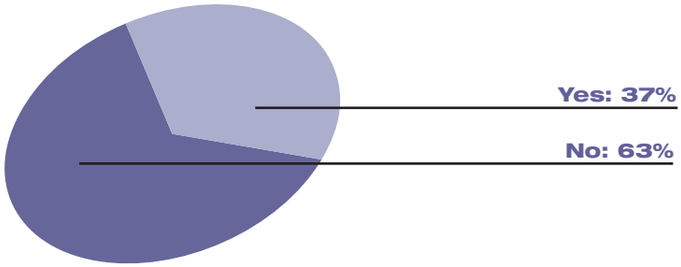
Ann Strickland, 49, mother of two children, a grandmother, a textile worker: set on fire in her sleep by her boyfriend

Cases in which perpetrator had history of or current problems with alcohol or drug abuse



52% had a history of or current problems with alcohol or drug abuse. Notably, in six (32%) out of 19 reviewed fatalities, there was suspected or confirmed alcohol use at the time of the homicide.

Cases where perpetrator had a history of or current problems with depression



Perpetrators in 37% of the reviewed cases had a history of or current problems with depression. Service providers and family and friends were aware of the perpetrator's depression in 43% of the cases where depression was indicated. In addition, law enforcement and criminal courts were aware of the perpetrator's depression in 29% of the cases where depressions was indicated.

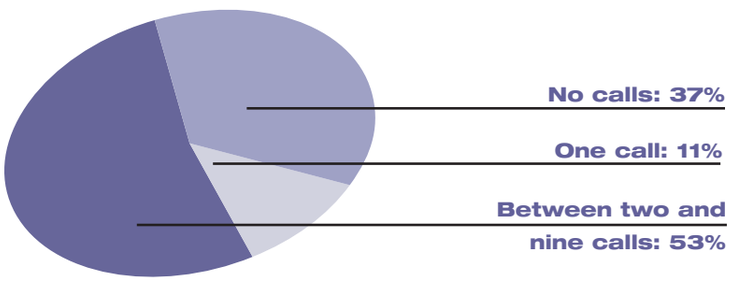
These findings indicate that someone knew about the perpetrator's state of mind and/or substance abuse in these cases and could have possibly intervened. Several communities and our Fatality Review Advisory Committee have recognized that these findings are compelling and are currently developing strategies to create awareness among traditional responders such as law enforcement as well as the general public.

Maricruz Martinez, 31, textile worker, shot in the head, and her boyfriend Lorenzo Fonseca, age unknown, shot in the back: both by her ex-husband, with her two children in the next room

SECTION 4: CIVIL & CRIMINAL HISTORY: LAW ENFORCEMENT, PROSECUTION, AND SANCTIONS

In the 19 cases reviewed, at least two domestic violence victims had TPOs in place and also filed for divorce. In one of the 19 cases, the domestic violence victim's TPO had expired 6 weeks before her death. In three cases, the domestic victims were actively pursuing a divorce as evidenced by the following actions: one called the shelter seeking information about divorce, another consulted with an attorney, and the third one told her spouse she wanted a divorce.

Number of Contacts with Law Enforcement Prior to Homicide (per case)
Note: Percentages may not sum to exactly 100 percent due to rounding.

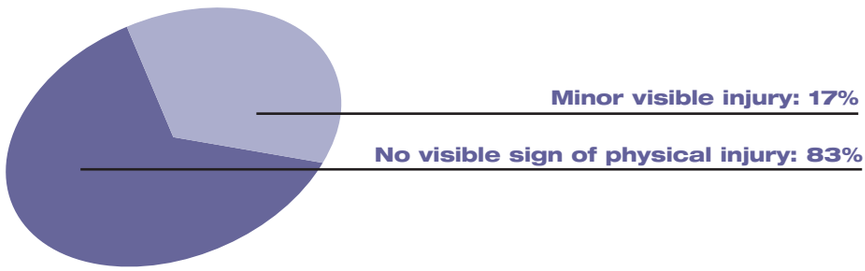


Cassandra Fulton, 38, worker in a disability rights organization: tied up and stabbed in the throat by her husband

Table 7: Prior Injuries Known in Reviewed Cases as Noted in Police Reports

	Number	Percentage
No injuries reported	31	76%
Perpetrator hit victim on face	7	17%
Scratches and minor cuts	4	10%
Bruises and contusions	4	10%
Busted lip	2	5%
Bloodied nose	2	5%
Perpetrator pulled victim's hair	1	2%
Perpetrator held gun to her head	1	2%
Perpetrator hit victim on body	2	2%
Perpetrator kicked victim	1	2%
Perpetrator grabbed victim's neck	1	2%
Broken bones	1	2%
Perpetrator pinned victim down	1	2%
Victim suicide attempt	1	2%

Renee Rushing Hill, 23, mother of an infant: shot in the head by her husband, who then killed himself



64% of the primary victims in the reviewed homicides called the police between 1 and 9 times as a result of violent incidents that took place prior to the homicide. Despite the large numbers of calls to the police, in only 17% of the known cases the domestic violence victim had minor visible injuries, whereas in 83% of the cases the victim had no visible injuries reported in the incident report by the police officer. This suggests that courts, law enforcement, and advocates should not rely solely on evidence of serious or even minor injury to the victim as an indicator of lethality.

Criminal Prosecution

Table 8: Progressive Loss of Cases

Original Event	Description	% of Cases
49 calls to police		
40 calls to police	Where case outcome is known	82%
19 Cases	Forwarded by police to prosecutor	48%
7 Cases	Charged by prosecutor	18%
4 Cases	Dismissed or pled down	10%
3 Cases	Proceeded as charged	8%

Out of 49 calls to the police, 40 (82%) calls have a known outcome. 19 (48%) calls to the police were forwarded to the prosecutor. Of the 19 cases, 7 (18%) cases were charged by the prosecutor and 4 (10%) of those cases were either dismissed or pled down. The remaining 3 (8%) cases proceeded as charged.

Table 9: Types of Incident Reports Filed by Police Prior to Homicide

Types of Incident Reports	Total # of Incident Reports	% of Incident Reports
Simple battery (non-FVA)*	8	33%
Simple assault (non-FVA)	2	8%
Aggravated assault (non-FVA)	1	4%
Simple battery - FVA	1	4%
Aggravated assault - FVA	2	8%
Aggravated stalking	1	4%
Cruelty to children - FVA	1	4%
False imprisonment	1	4%
Obstruction of 911 call	1	4%
Terroristic threats	1	4%
Burglary	1	4%
Theft by taking	2	8%
Theft by conversion	2	8%

** FVA=Family Violence Act*

Note: Percentages may not sum to exactly 100 percent due to rounding.

Rubia Neves, 37, mother of three children, cleaning service worker and active church member: stabbed multiple times by her husband in the presence of her youngest child

Table 10: Criminal Dispositions for Charges Filed Prior to Homicide

	Total number of charges	Percentage of all charges
Guilty	4	17%
Open at time of fatality	2	8%
Nolle Prosse	4	17%
Not charged by prosecutor	14	58%

Another area where intervention could potentially impact homicides is with the prosecution of misdemeanor cases. 80% of incident reports filed by the police prior to the fatality were misdemeanors. The prosecution of misdemeanor domestic violence cases provides an opportunity for the criminal justice system to intervene and de-escalate the perpetrator's violence before it leads to homicide.

SECTION 5: COMMUNITY SYSTEMS INVOLVED IN THE 5 YEARS PRIOR TO THE HOMICIDE

The Domestic Violence Fatality Review Committees identified agencies and community entities or systems with which the domestic violence victim and/or perpetrator were involved in the five years prior to the homicide.

Table 11: Agencies / Services / Programs Involved with Victim or Perpetrator in the Five Years Leading up to the Homicide

AGENCY / SERVICE / PROGRAM	VICTIMS		PERPETRATORS	
	Number	% of Total Cases	Number	% of Total Cases
Justice System Agencies				
Law enforcement	14	74%	14	74%
City prosecutor	0	0%	2	11%
County prosecutor	7	37%	9	47%
Magistrate court judge	4	21%	3	16%
Municipal court judge	1	5%	1	5%
State court judge	2	11%	5	26%
Superior court judge	6	32%	7	37%
Civil divorce court	3	16%	3	16%
Court-based legal advocacy	2	11%	1	5%
Protection order advocacy program	2	11%	1	5%
Probation	2	11%	5	26%
Parole	1	5%	2	11%
Legal aid	1	5%	0	0%
Social Service Agencies				
Child protective services (DFCS)	1	5%	1	5%
Child care services	2	11%	1	5%
WIC	0	0%	0	0%
TANF or Food Stamps	0	0%	0	0%
Homeless shelter	0	0%	0	0%
Health Care Agencies				
Mental health provider	2	11%	4	21%
Medicaid	0	0%	0	0%
PeachCare	0	0%	0	0%
Private physician	2	11%	3	16%
Emergency medical care	2	11%	1	5%
Hospital care	2	11%	2	11%
Emergency medical service (EMS)	3	16%	3	16%
Substance abuse program	0	0%	1	5%
Family Violence Agencies				
Domestic violence shelter or safe house	2	11%	0	0%
Sexual assault program	0	0%	0	0%
Community-based advocacy	0	0%	0	0%
Family violence intervention program (FVIP)	1	5%	1	5%
Miscellaneous Agencies				
Religious community, church, or temple	3	16%	3	16%
Immigrant resettlement	0	0%	0	0%
English as a Second Language program	0	0%	0	0%
Anger management	0	0%	1	5%
TOTAL NUMBER OF CASES: 19				

Annisha Sutton, 24, recently returned from enlisted military service in Iraq, and her son, Shaun Sutton Jr., 22 months: both shot in the face in the presence of the victim's young daughter, by her husband, who later killed himself

Findings & Recommendations

Issues identified as findings and recommendations are not limited to individual cases. Instead, they are the product of Fatality Review Committees identifying practices that not only impacted a specific homicide, but were common problems throughout their community. For this report we have further narrowed findings and recommendations to those that were replicated among several communities.

Alcohol and Drug Treatment

Finding: Alcohol and drug abuse were identified in many cases as a factor – not a cause – in the escalation of danger. Treatment resources remain woefully inadequate for the need. Newer drugs such as methamphetamine have exacerbated an already persistent problem with treatment resources.

Recommendation: Communities must work in a focused way to identify and advocate for increased funding for alcohol and drug treatment resources, including development of more peer-based programs such as Alcoholics Anonymous and Narcotics Anonymous.

She had just gotten a job and was planning to go to her friend's wedding out of state.

Children

Finding: Children remained largely invisible to interveners as the violence in families escalated. Even when communities were somehow involved with the family prior to the homicide, they struggled with how to assist children who live with and witness on-going domestic violence. Some communities felt that intervening earlier with children might have made a difference for them as well as helped to prevent the homicide.

Recommendation: Through their task forces, communities should develop protocols of outreach and respond to child witnesses of domestic violence based on models which show promise (such as Boston's hospital-based outreach project, the Green Book Initiative, projects utilizing school counselors, and others).

Recommendation: Schools, with the assistance of their local domestic violence task force, should develop protocols to assist teachers, counselors and other personnel in identifying and reaching out to children who are living with on-going domestic violence.

Domestic Violence Programs

Finding: Some domestic violence hotlines focus exclusively on the needs as presented by callers, but do not proactively ask about or plan for safety unless the victim raises this issue.

Recommendation: All domestic violence hotlines should include policy and training which ensure that workers will proactively screen for danger and do safety planning with all victims who call hotlines, even if the focus of the call is on a related matter (legal questions, financial needs, getting belongings, etc.).

She just came back from serving her country in Iraq. She told her sister that she was trying to save money so she moved the family off of the military base.

Domestic Violence Programs (continued)

Finding: The vast majority of women killed in Georgia had not accessed supportive services through the system of shelters and programs which exist to assist them. Some communities felt that because we call these programs "shelter" and they focus most of their resources on shelter, victims do not know the other kinds of assistance they can receive from these programs. (This finding supports a study by the Duluth Abuse Intervention Project which found that only 1 of every 29 domestic violence victims seeks shelter).

Recommendation: Domestic violence programs should receive increased funding to develop outreach and non-residential services to victims who may not need or desire shelter, but who are in desperate need of information, resources, safety planning, advocacy and supportive services.

She informed her batterer that she had accepted a job with another company and would no longer be working for him. He moved out of the marital residence three weeks prior to the homicide.

Employers

Finding: Most victims and offenders involved in the reviewed deaths were employed. In many cases, co-workers and supervisors knew about the abuse.

Recommendation: Employers should seek out training from domestic violence organizations regarding how to create a work environment which allows victims to disclose the abuse, and which accommodates the safety needs of all employees. (For additional information, see the Family Violence Prevention Fund manual on workplace response).

Recommendation: Employers, through supervisors, Human Resources and Employee Assistance Programs, should link employees dealing with domestic violence either as victims or abusers to local resources.

Family, Friends and Community

Finding: Family and friends of both victims and abusers are often very knowledgeable about the level of abuse, but do not know when things have become more dangerous, or how to help increase the safety of their loved ones. Often other individuals such as landlords know about the abuse but are not armed with the information they need to be of assistance.

Recommendation: A state-wide brochure is needed which can be distributed by local shelters, advocates, task forces and others which educates the general public about danger and how to help a loved one who is either being abused or being abusive.

She called the police three times in the three months prior to her death.

Family Violence Intervention Programs (FVIPs)

Finding: Many domestic violence offenders who are ordered to attend FVIPs do not attend, and many of these individuals are not reported back to the courts by FVIPs.

Recommendation: FVIPs should ensure that they have a system that allows them to monitor attendance of abusers ordered through civil and criminal proceedings and should have and use internal policies which ensure that non-compliance is promptly reported back to courts.

Language Access

Finding: First responder systems (law enforcement, hotlines, and courts) often do not have access to respond to victims and offenders in languages other than English.

Non-English speaking batterers receive Temporary Protective Orders which are meaningless to them because they are written in English.

Non-English speaking victims receive outreach letters from prosecutor's offices which are meaningless to them because they are written in English.

Children are used as translators, often exposing them to adult information that is age-inappropriate and/or traumatic.

Recommendation: All first responders in Georgia need a simple brochure that says "I Speak" in the most common 15 languages spoken here, to assist them in identifying the language of both victims and perpetrators. The language of the victim and the offender should be noted in the law enforcement report. Downloadable versions of the "I Speak" brochures can be accessed on the World Wide Web at http://www.lep.gov/.

Outreach letters and Temporary Protective Orders must be translated into the languages the victim and the offender speak.

First responder systems in Georgia (ex, law enforcement, hotlines, and prosecution-based advocates) must follow Title VI and provide language interpreters, if by no other means than through a telephone-based interpreter service (i.e. TeleInterpreters).

She moved out twelve days prior to her death and told him she wanted a divorce. One week before her death she called the shelter seeking information.

Legal Issues

Case Loss

Finding: There remains state-wide a persistent case loss problem, i.e. the percentage of cases prosecuted from those charged at the scene is dismally low. Most cases are never prosecuted and a significant number of cases filed are dropped or pled down, even when evidence exists to go forward. This problem permits serious domestic violence offenders to have frequent contact with the police without any consequence, increasing danger to both responding officers and to the victim and children.

Recommendation: When evidence of a crime exists, prosecutors should aggressively prosecute crimes of domestic violence, particularly in light of the escalating and repetitive nature of this crime.

Communities who are concerned about a lack of prosecution in their location should consider creating Court Watch programs to monitor the number of offenses police officers handle as compared to the number of cases that successfully make it to and through the court system.

Case Duration

Finding: In some communities there is an extensive period of time between arrest and prosecution. This delay reduces the impact of the criminal justice system on domestic violence.

Recommendation: Because domestic violence is a high recidivism crime with an escalating nature, courts should prioritize these cases to minimize the time they remain open with no resolution.

She called the police and had her locks changed after he strangled her, three weeks before her death by strangulation.

Bond Determinations

Finding: Judges do not consistently have access to, or consider a domestic violence offender's criminal history when setting bond. As a result, dangerous domestic violence offenders who may have significant criminal histories are often able to move in and out of the criminal justice system with the same low scrutiny as first time offenders.

Recommendation: Judges must have access to the full offense report and the offender's criminal history at the time bond is determined, so that they can fully evaluate potential danger to the community.

Prosecuting in Dual and Questionable Arrests

Finding: Because dual arrest and primary aggressor determination remain challenging areas for law enforcement, cases of domestic violence victims being wrongfully prosecuted continue to happen.

Recommendation: Solicitor and District Attorney Offices should develop written protocols for prosecution-based advocates and prosecutors for identifying and averting wrongful prosecution.

Case Outcomes & Sentencing

Finding: A troubling number of judges in criminal and civil cases in Georgia do not follow federal statutes which require them in certain circumstances (civil TPOs, criminal findings of guilt) to order guns to be removed.

Recommendation: Judges should follow federal statutes and order guns removed when required, recognizing, as our Congress has, the substantial number of domestic violence homicides which are committed with guns (74% in Georgia, 2003) and their unique opportunity to prevent further injury and death.

Finding: Some judges continue to send domestic violence offenders to anger management programs, although Georgia statute requires that offenders be sent to certified Family Violence Intervention Programs O.C.G.A. 19-13-16 (a). In addition to this practice contradicting law, such orders allow abusers to evade addressing their core problems, which do not – according to a broad sampling of research – relate to the management of anger.

Recommendation: All judges should order domestic violence offenders, pursuant to the statute, to certified FVIPs, recognizing the expertise of these programs and the benefits of them being regulated (i.e. that they are initially evaluated for knowledge, training and experience, receive oversight and technical assistance from the Georgia Commission on Family Violence, and require continuing education to maintain certification).

Finding: Some domestic violence offenders who are ordered by the court to attend FVIPs never attend, and are never brought back to the court to face the judge.

Recommendation: Local communities, through their task forces or other means, should develop mechanisms to monitor abuser compliance with court orders and impose sanctions when abusers ignore court orders.

Finding: Even though the vast majority of domestic violence crimes were never prosecuted, when cases are successfully prosecuted, many abusers leave court with minimal or no sanctions, increasing their sense of license to re-offend, and decreasing the chances the victim will seek help from the court in the future.

Recommendation: Courts should carefully consider the private, escalating and repetitive nature of domestic violence when imposing sanctions.

She moved on with her life while he was in jail on felony charges stemming from an assault against her. He killed her and her boyfriend four months after his release from jail. Her TPO expired 6 weeks prior to her death.

After extreme isolation, she obtained employment. Two months later he killed her.

Coordination of Information

Finding: Court systems are made up of many professional systems: law enforcement, prosecution, prosecution-based advocates, probation, judges and parole. Frequently, these people do not communicate with each other when they have valuable information or real concerns about escalation of violence.	**Recommendation:** While agency coordination is not possible in all cases, court and law enforcement personnel must recognize how their lack of communication supports the escalation of violence. Especially when any person has concerns about danger, they must take the time to call on others involved in the case to discuss and coordinate intervention. **Recommendation:** In communities where the case load is of sufficient size to warrant it, specialized units and dockets should be created, following national models, for detectives, prosecutors and judges, to create focused expertise, better coordination, and a system better prepared to hold offenders accountable.

Law Enforcement and 911

Finding: There appears often to be a gap between written policy and practice in law enforcement agencies.	**Recommendation:** Law enforcement organizations should institute offense report reviews on an on-going basis to monitor adherence to policy, and to reduce liability and danger to officers and victims.
Finding: In many instances, an offense report is not created after a dispatch for a domestic violence incident.	**Recommendation:** Law enforcement agencies should monitor any discrepancies between the number of dispatched calls and the number of offense reports written.
Finding: Dual arrests remain a regular practice in domestic violence cases.	**Recommendation:** Law enforcement agencies should monitor the level of dual arrests, and consider implementing training and accountability mechanisms whenever dual arrest rates exceed 3% of all arrests for a monitored period, by department and by officer.
Finding: Arrests of battered women continue to occur at questionable rates. A portion of the women who were murdered had called the police for help and had instead been arrested, for what appeared to be flawed primary aggressor assessments.	**Recommendation:** Law enforcement agencies should monitor the level of female arrests and, based on research, implement corrective action any time the rate exceeds 5% in cases of female perpetrators of male victims. **Recommendation:** Law enforcement agencies should institute on-going training on primary aggressor determination.
Finding: Many officers responding to domestic violence calls do not know any information regarding the history of calls to that address, increasing danger for them and the victim and children.	**Recommendation:** Dispatch protocols should include conveying to responding officers all information regarding prior calls that can be accessed. Departments where access to prior calls is limited should address this problem.

She was arrested and charged with a felony after the police were summoned to her home regarding an assault against her. He was previously convicted of breaking her nose and wrist and killed her less than two months after she was released from jail.

She had recently received her high school diploma.

Probation

Finding: There is inconsistent practice in revocation of probation in Georgia. Many offenders on probation re-offend or commit technical violations (ie. violation of no contact orders, failure to attend mandated programs) but the standard required to revoke probation varies.	**Recommendation:** Where evidence supports the likelihood that a violation has clearly occurred, probation officers should have and enforce clear policy that revocation should be sought with the appropriate party as soon as the probation officer learns of the violation.
Finding: Case loads prevent close monitoring of dangerous probationers.	**Recommendation:** Probation officers should engage in risk assessment (see "Assessing Danger, Planning for Safety" in this report). Intensive supervised probation (more frequent contact, more collateral contacts, etc.) should be provided to a smaller group of high-risk domestic violence offenders who are assessed as particularly dangerous. (This recommendation may overlap with recommendations pertaining to judges where judicial orders may be required to obtain intensive supervised probation.)

She had recently accepted a management position with her job. A twelve-month protective order was granted five days before her death and she had recently filed for divorce.

Temporary Protective Orders

Finding: Some courts do not make the pro se forms available to domestic violence victims.	**Recommendation:** All courts should make the pro se forms available with a referral to a local victim advocate and the civil legal assistance project through GCADV.
Finding: Some courts and attorneys allow the TPO to be subsumed in the divorce filing by letting the TPO expire or be dismissed and seeking the relief through motions in the divorce instead. At the scene of a violation of these terms, if no TPO is in place, law enforcement is limited in the actions they can take.	**Recommendation:** Courts and attorneys should recognize that TPOs have unique enforcement mechanisms that are not activated by similar pleadings in the divorce.
Finding: Some courts will not hold batterers accountable for violating a TPO if there is an allegation that the victim invited the batterer, or otherwise had what appears to be voluntary contact.	**Recommendation:** Courts should recognize that some victims may appear conciliatory with persons they have sought TPOs against because of economic dependency issues or because they believe this will help avert another assault. Many offenders use the "invitation" defense based on a frequently held belief by abusers that they don't have to follow the court's order if they can get the victim to agree to have contact with them. Courts should educate batterers that they alone are the subject of the order, and that despite any contact from the victim, they alone will be held accountable for violating the order.

She had made it clear to her husband that she was tired of his drug addiction and was not going to stay with him.

Media

Finding: Some reporters appear to need education about domestic violence dynamics. As a result of their lack of familiarity with this issue, many report on homicides and other cases in ways that blame victims and discourage other victims from seeking help. Such reporting also supports abusers who continue to blame others for their violence.

Recommendation: Georgia media outlets should seek and attend training on the complex crime of domestic violence in order to cover it appropriately, and should consult with domestic violence experts in their communities to assist them in understanding the difficult nuances of these cases.

Military

Finding: Victims who are military personnel face specific barriers when they seek help from military personnel, which may issue orders for the victim to follow. These orders may ironically result in consequences to the victim seeking help from the military.

Finding: Victims of domestic violence have limited privacy and confidentiality in the military.

Recommendation: Victims seeking assistance should never be ordered to take specific actions related to their victimization, when violation of such orders could produce consequences, and a future reluctance to report abuse or danger.

Recommendation: Branches of the military should adopt policy to assist them in addressing domestic violence among enlisted and civilian personnel, in compliance with the Department of Defense administrative directive DD 6400.1. In doing so, military communities should utilize national protocols developed for military response.

She was considering a job offer that would relocate her to New York. She confided in her friends that she was going to end the relationship in the beginning of the New Year and was killed two weeks later.

Missing Community Partners on Review Teams and Task Forces

Finding: Many teams identified missing community partners as a factor that hampers their ability, both on fatality review and domestic violence task forces, to improve victim safety and batterer accountability.

Recommendation: Fatality review teams and domestic violence task forces should identify which key community systems are missing at the table and make it a priority to recruit representatives from these systems. In different communities this list may include any or all of the following: public defenders, schools, 911 dispatchers, EMS, faith leaders, homeless shelters, employers, and judges.

She worked a full-time and part-time job. She had just received the employee of the month award at her part-time job.

Suicide

Finding: A substantial number of domestic violence perpetrators who killed their partners – and in some cases others – had a history of depression and talk of suicide. In many cases, people around the abuser knew he was depressed and suicidal but did not understand the danger this presented for others.

Recommendation: Interveners in many systems - probation, shelters, courts, clergy, employers, medical, parole and others – must be trained to understand the significant connection between depression, suicide and homicide, and when they hear about this factor through abusers or victims, they must act on this information. Specifically, those working with offenders should notify the victim and do everything in their power to get the abuser the help he needs. Those working with victims should screen for indicators of depression and suicide in abusers, educate victims about how this factor increases danger to them and their children, and do safety planning to avert homicide.

She created a safety plan with her employer and weeks prior to her murder, after her separation from her husband, she called the shelter and inquired about assistance for a divorce.

Survivors of Homicide

Finding: Many Review Teams identified the need for services to homicide survivors as a major gap in victim services in Georgia. Specifically, teams indicated that these services are not typically provided through the prosecutor's office when the case is not handled in the criminal justice system because the offender committed suicide (a substantial percentage of cases), or when there is tension between the family and the prosecutor's office.

Recommendation: Georgia needs an outreach program to link homicide survivors to the many services they will need: financial services, crime victim's compensation, advocacy and case management, grief counseling, parenting support, etc. Initially, a brochure listing state-wide resources should be developed so that it could be provided to homicide survivors immediately following the death.

Recommendation: Georgia needs a specific project to respond to children who are present at or witness a domestic violence homicide, or who lose one or both parents to domestic violence homicide.

Training

Finding: Every Review Team identified the need for additional training for workers in every system as primary – law enforcement, shelters, DFCS, military responders, probation, parole, judges, prosecutors, employers, FVIPs, clergy, medical, jury pools, etc.

Recommendation: Task forces in Georgia need to substantially increase the trainings they organize to ensure that frequent training is available.

She filed for a divorce weeks prior to the murder. Days prior to the murder she had her attorney file a restraining order requesting that her husband be removed from the home and not harass her at home or work.

Assessing Danger, Planning for Safety

There are many efforts occurring around the country to determine which factors indicate an increased risk for danger. The bottom line is there is no single factor or set of factors that are 100% sure indicators of increased risk for serious injury or homicide. Yet several factors have emerged from the research that can be considered significant in contributing to an increased risk for homicide. (see chart below)

Forming an impression of danger is both art and science. There are those who market checklists and scored factors, and even software that predicts homicide. The best assessments of risk factors for danger include 3 main elements:

- the presence of a combination of factors that are commonly viewed as posing increased risk
- the victim's view of the factors
- the "hair on the back of the neck" factor

When we talk about the victim's view of factors, a few points of clarification are in order. Our first principle of assessing danger is to listen to what the victim believes – what is happening, what does it mean, how is it different from other abuse, and what does she believe is the intent of the abuser's behavior. However, the nature of trauma is that it can deaden one's sense of terror or fear over time. Denial and minimization are hallmark reactions to severe and on-going trauma. So, the second principle of assessing danger is to assess for denial and minimization and to look at the factors ourselves in addition to the victim's assessment.

The "hair on the back of the neck" factor is intuition. If a case is causing you concern, explore that, react to it, and listen to it. Sometimes, a particular combination of factors, or the timing or details of factors just lead you to feel there is great risk. This is part of the art of assessing danger, and is a valid part of the process.

The chart below is a list of several factors that have emerged from the research and can be considered significant in contributing to an increased risk for homicide.

Table 12: Danger Factors

	Source: Georgia Fatality Review Project	Source: Neil Websdale research	Source: Jacqueline Campbell, et al, research	Source: Barbara Hart*	Source: Other research
Escalating violence	X		X		
Threats to harm or kill	X	X	X	X	
History of violence	X	X	X	*Homicide attempts*	
Isolation, monitoring and controlling behavior (severe)	X		X	X	
Depression and suicidal thoughts	X	X	X	X	
Drugs and alcohol	X	X	X *(drugs only)*	X	
History of police and court involvement	X	X			
Obsession with victim	X	X		X	
Rage				X	

Table 12: Danger Factors (continued)

	Source: Georgia Fatality Review Project	Source: Neil Websdale research	Source: Jacqueline Campbell, et al, research	Source: Barbara Hart*	Source: Other research
Nothing to lose	X		X		
Strangulation	X	X			X
Forced sex	X				
Dependency on victim	X			X	
Stalking	X	X	X		
Child abuse	X		X		
Abuse during pregnancy	X		X		
Fantasies/dreams of homicide	`X			X	
Violence toward others/ public violence	X				
Hostage taking	X				
Ownership of victim	X				
Pet abuse	X				X
Victim is separating or gaining independence	X	X*(even higher if court order in place)*	X		
Victim's level of fear (accounting for denial mechanisms)	X		X		
History, access to, willingness to use weapons	X	X*(access, fascination)*	X*(threats with weapon)*	X	
Sleep disturbances	X	X			

- In addition, Barbara Hart notes that the following series of factors elevates those she sees as primary: attempts, threats, or fantasies of homicide or suicide.
- Some research indicates that the availability of prompt medical care is also a factor in predicting homicide (i.e., victims isolated from medical treatment are at increased risk for homicide).
- The research by Websdale and Campbell offers more detail about particular combinations of factors that they found to be statistically significant. For the purposes of overview here, if the factor in combination with others was found significant, it is marked on this chart.
- Neil Websdale's research can be viewed on the World Wide Web at http://www.ndvfri.org/.
- "Risk Factors for Femicide in Abusive Relationships: Results From a Multisite Case Control Study" Campbell et al. July 2003, Vol 93, No. 7, *American Journal of Public Health*.

DOMESTIC VIOLENCE & SAFETY PLANNING QUESTIONS

Here are some questions you should ask yourself and the domestic violence victim as you engage in safety planning.

Screening Questions

Disagreements happen in all relationships. What happens when you and your partner disagree? Are you free to disagree? Do you dread your partner's reactions to certain things? Have you ever felt afraid of your partner? Do you change what you say or do to avoid the consequences from him/her?

Questions to Ask About Your Community Before Safety Planning

- Can she access legal assistance (eligible by income and case type)?
- How far is local TANF office? Do they give work waivers to domestic violence victims?
- What are DFCS policies about children and DV in my community?
- What is typical police response? How likely is he to bond directly out from jail if arrested?
- Is the case likely to be prosecuted or dismissed or pled down?
- What is the typical sentence for a first offense?
- How likely is his probation to be revoked if he continues to stalk/abuse/threaten?
- How far is the closest abuser program (FVIP)? Will they hold him accountable?
- Are there clergy who prioritize safety?
- Can she access shelter? Are they often full? Will they take women with chemical dependency, mental health issues, language issues, disabilities, etc.?
- What language services can I find for deaf women or non English speaking clients?
- What public transportation exists to get to the resources the victim needs?
- How affordable is housing in my community?

Safety Planning Questions to Ask Victim

- What has he done? *Last Abuse, Worst Abuse, Most Recent Abuse*
- What has he threatened to do? Can he do it? Is he likely to do it?
- What does his behavior right now mean to you? Is the abuse changing?
- Which factors from the checklist are present?
- Do you feel you are in danger now?

Safety Planning Questions to Ask Yourself

- Can she access the resources needed?
- Can she go through the processes planned?
- How long will it take, and does this fit the timeline of her need?
- Is this plan hers or mine? Is it based on what she can and will do?
- What things could go wrong with her accessing this option? How can the abuser interfere with it? Are there community partners in this plan that are unpredictable?
- How could it backfire?

The main thing to remember about safety plans, is that **they belong to the victim, not us.** We can create what seems to be a wonderful safety plan, but if it doesn't belong to her, if she didn't help create it, it is not a safety plan. It is your case plan. Our role in safety planning is to ask the right questions, provide information we have about danger factors, provide resources, and brainstorm. Ultimately, the plan has to fit her life, her resources, and be made up of steps she can and wants to take. If we remember this core principle in safety planning, the work we do with victims has a better chance of resulting in increased safety.

NOTE: Advocates are trained to safety plan with victims in various situations. Please always refer victims to a victim advocate. Local domestic violence shelter programs can be reached by calling 1-800-33-HAVEN. For information on best practices for safety planning with battered women, see *Safety Planning with Battered Women*, by Jill Davies, Sage Publications, Inc. 1998.

Transforming Communities

When a community experiences a domestic violence-related fatality this raises the question, "How could this have happened?" The fatality review process takes this question to the next level and asks, "What needs to **change** to prevent this from happening again?" In fact, **change** is the point of the fatality review process.

In depth reviews of domestic violence fatalities provide an opportunity for communities to evaluate their current response to domestic violence and identify opportunities for **change**. Once the gaps in the current response have been identified, communities must then develop a plan to implement their recommendations. The greatest challenge that so many communities face is the actual implementation of their recommendations. This is due in part to the fact that it is easier to rely on practices and policies that have existed for years, rather than engage in a process that promotes **change**.

The good news is that the policies and practices of agencies charged with intervening on behalf of families experiencing domestic violence are **change**able. Several communities have already taken on the difficult task of evaluating their current response, identifying gaps, and implementing a plan for **change**. We have highlighted several areas where communities are currently working to implement **change**s identified through the fatality review process:

Courts

Following other national movements that have created court watch programs, Fatality Review Committees are creating court watch programs to get their community more involved in learning about and monitoring domestic violence cases.

One community saw the need to educate potential jurors about the dynamics of domestic violence. In an effort to address this need, members of the Fatality Review Committee presented to two Grand Juries on this issue.

Family and Friends

There is a lack of community support and resources for family and friends of domestic violence victims attempting to intervene on the victim's behalf. One community is currently creating a safety planning brochure for family and friends of domestic violence victims. It includes talking points for the support network of domestic violence victims and informs interveners about how their efforts can have implications for their own personal safety.

Children Who Witness

Several communities have found that surviving children of domestic violence homicides are not receiving adequate follow-up services (i.e., therapy for witnessing the homicide or seeing or discovering the deceased). A pilot project is currently tracking information regarding surviving children of domestic violence homicides with the goal of building support services for this population.

Faith Based Community

One community recognized the importance of involving the faith community in their coordinated community response to domestic violence. They are currently working with the ministerial association in their community regarding domestic violence training opportunities for faith leaders.

Community Awareness

In honor of Domestic Violence Awareness Month, one community displayed the Silent Witness Project silhouettes in nine community areas covering their three-county judicial circuit including the local high school, courthouse, and community recreation center.

Medical

One community conducted a training for healthcare providers to educate them about domestic violence and provided them with a Domestic Violence Protocol for Healthcare Providers that was drafted by members of the Domestic Violence Task Force.

Law Enforcement

One community is currently developing a uniform accountability survey to capture information from domestic violence victims regarding their experiences when officers respond to domestic violence calls.

Another community is providing domestic violence training to officers during their roll calls.

Employers

Several communities are working on efforts to educate employers and increase their awareness of domestic violence by providing them with information, resources, and training.

Is Your Community Ready?

The review of domestic violence-related fatalities is a valuable process that yields concrete recommendations for improving systemic response to domestic violence victims and for reducing future homicides. Most communities recognize the value of evaluating their current response to domestic violence with this goal in mind. However, it is not uncommon for participants to experience fear and challenges when engaging in a process that seeks to identify missed opportunities for meaningful intervention.

One of the most common fears expressed by individuals who have participated in the Georgia Fatality Review Project is that this process would be an opportunity to cast blame and point fingers. In fact, pointing fingers and assigning blame would be counterproductive. One of the most important principles that fatality review is rooted in is that of "no blame, no shame." It is important for all fatality review participants to understand that this process does not seek to assign blame to agencies, individuals, or institutions, but rather that all participants must be willing to engage in agency self-critique in order to thoughtfully examine their own policies and practices. Fatality Review Committees work from the assumption that all participants have individual knowledge and expertise to contribute to the process.

One challenge that has been identified by communities participating in the Fatality Review Project is organizing the Fatality Review Committee itself. When forming a review committee, it is important to have a multi-disciplinary panel composed of participants that are charged with responding to domestic violence. It is equally important to include individuals with influence that have the leverage to implement necessary changes. Ideally, at a minimum, a review team includes representatives from the following systems: law enforcement, shelter and prosecution-based advocates, prosecutors, probation, Family Violence Intervention Programs, Department of Family and Children Services, and judges. Other representatives to consider include the following: faith leaders, medical professionals, schools, employers, mental health and substance abuse treatment providers, child care providers, parole officers, TANF workers, sexual assault programs, immigrant and refugee services, anti-poverty programs, public health and other community service providers.

In 2006, the Fatality Review Project will not be limited to the communities that have participated thus far. If your community is interested in fatality review please contact the project to discuss possible participation. Communities tell us that the benefits of fatality review far outweigh their original fears and challenges. In the words of one team member, "I have learned that fatality review is a necessary tool in our fight to end domestic violence. The information that is obtained in the process is imperative to make changes within our community."

What Is My Role?

For years the battered women's movement has focused much of its work on improving how police and courts respond to domestic violence. The vast majority of available funding focuses on services to victims involved in the courts. Our focus has logically remained on the criminal justice system because it has the power to impose significant sanctions: incarceration, mandatory batterer intervention, monitoring through probation, and restitution and fines. All of these factors have solidified an assumption that the police and courts are largely responsible to intervene in domestic violence and to prevent further injury and death. Fatality review findings are telling us that nothing could be further from the truth.

If there is one single most important finding from the first two years of fatality review, it is that we must broaden our understanding of who can stop domestic violence and related homicide. As long as we continue to believe that the police and courts must handle this problem alone, we ignore our own role, to the peril of families living with domestic violence.

Two years of fatality review have revealed that family, friends, co-workers and other community members knew more than anyone else about how the domestic violence escalated to homicide. The vast majority of victims killed were not connected to victim advocacy programs or domestic violence shelters. The review committees have also continued to find that many victims, for complex cultural and practical reasons, do not call upon the criminal justice system to help stop the violence in their lives. And clearly, many committees uncovered the reality that when victims did call upon the criminal justice system, their efforts ultimately did not bring about the change they were seeking.

The really good news here is that the ranks of those who can stop family violence are much larger than we ever knew. While families should always have the option to utilize the formal systems to intervene, there are a host of others who can help identify the violence, reach out and begin to help intervene. We found that victims had talked with their co-workers, family members, clergy, the person who cut their hair, their medical care providers and others. People at the children's school knew about the violence, and in some cases, even the victim's employer was involved.

While we continue to try to improve traditional systems of response- police, courts, shelters- let us not do so to the exclusion of other valuable community partners. When we recognize these allies and provide them with information and tools for intervention we will find they can play an immensely important role. For victims who will never call on the traditional systems about the violence in their lives, the role of their community is the only one that matters. It is our job to make sure that the community that surrounds victims and their children has the information needed to be an effective force for creating safety. Only when we truly understand that everyone has an important role can we begin to marshal the forces needed to reduce family violence and related homicide in Georgia.