# 2008 GEORGIA DOMESTIC VIOLENCE FATALITY REVIEW ANNUAL REPORT

*an in-depth review of the circumstances and consequences of 65 domestic violence fatalities from 2004 to 2008*

*Georgia Commission on Family Violence*
*Georgia Coalition Against Domestic Violence*

Listed here are the names of victims whose cases were reviewed from 2004 to 2008. This report is dedicated to all those who lost their lives to domestic violence and to their family members, friends, and surviving children who must go on without them.

03/09/98 **Nina Albright**, 23, bludgeoned to death by her daughter's father who then attempted suicide and survived

05/12/04 **Tomeka Baker**, 29, strangled by her boyfriend who then burned her body in an attempt to cover the crime

12/27/04 **Eliete Barcelos**, 33, shot by her former boyfriend who then killed himself

07/16/98 **Vivian Bell**, 39, stabbed to death by her husband on her birthday

10/15/06 **Stacy Boddie**, 35, shot in the abdomen and head by her husband who then killed himself; their twelve-year-old daughter in the adjoining room was awakened by her mother's cries for help

05/22/04 **Celestine Brannan**, 42, stabbed multiple times by her estranged husband who was stalking her

04/16/03 **Sharon Callen**, 36, kidnapped by her estranged husband who shot her when she attempted to escape; he later killed himself

08/12/96 **Jennifer L. Cole**, 44, stabbed over 100 times and beaten by her husband

12/10/01 **Kecia Conley**, 20, shot in the head by her boyfriend who concealed her body in a trash can

04/27/04 **Flossie Cooper-Tyson**, 54, shot by her estranged husband who then killed himself

03/19/04 **Wanda Corbin**, 49, beaten in the head with a blunt object by her husband after years of abuse

01/29/03 **Michael Covington**, 40, shot in the chest by his live-in partner, who then killed himself

07/14/00 **Deborah Cuadra**, 45, shot by her husband who then killed himself

01/08/00 **Jamitra Ector Davis**, 30, shot to death by her husband who then killed himself; he also shot her mother, who survived

05/03/03 **Patrice Nicole Edwards**, 19, hit in the head with a hammer and strangled by her boyfriend whom she was in the process of leaving after a year-long relationship

01/28/03 **Elizabeth Ellison**, 36, shot in the back by her husband who then attempted to kill himself

10/02/01 **Mary Lucille Fain**, 61, shot at close range with a shotgun by her boyfriend

01/22/00 **Judy Lynn Fetzer**, 35, beaten by her boyfriend

10/01/03 **Cassandra Fulton**, 38, tied up and stabbed in the throat by her husband

02/16/02 **Breanna Moses Funderburk**, 24, strangled by her estranged husband one week before her 25th birthday

08/20/03 **Gwendolyn Gaddy**, 40, shot in the head and chest by her estranged husband

11/17/05 **DeeDee Marie Golden**, 35, died from trauma to the head and neck by her husband, who buried her body to conceal the homicide; their fifteen-year-old son was in the house when the homicide occurred

12/02/01 **Renee Rushing Hill**, 23, shot in the head by her husband who then killed himself

12/25/01 **Marlene Huggins**, 37, and her daughter, 13, shot to death by their husband and father who then killed himself

05/30/96 **Stephanie Jenkins**, 33, shot in the back by her husband

03/03/05 **Mccine Brown Johnson**, 36, shot multiple times by her husband whom she was planning to leave after a long history of abuse

06/21/01 **Nikita Freeman Jones**, 22, stabbed and beaten by her husband in front of her three small children

01/18/00 **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

04/18/05 **Pearlie Mae Kennedy**, 47, stabbed to death by her live-in boyfriend after she told him that she did not want to be in a relationship with him anymore

06/10/04 **Marina Khomenko**, 33, stabbed by her estranged husband who then killed himself

03/03/03 **Carolyn Williams Lackey**, 35, shot in the head by her husband in the presence of her infant grandchild

03/20/05 **Rebecca Lamastro**, 36, shot to death by her estranged husband in the presence of their child; he later killed himself

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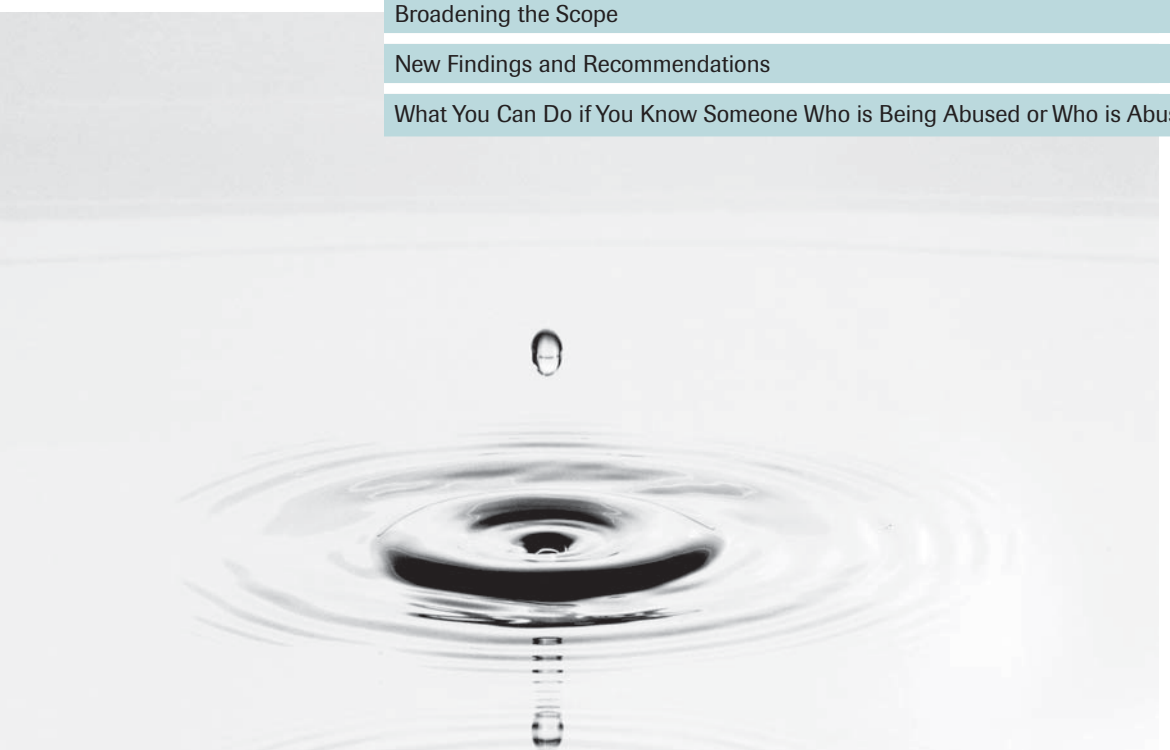

Copies of this report and all previously published reports can be downloaded online from the following websites:
*www.gcfv.org*
*www.gcadv.org*
*www.fatalityreview.com*

Statistics compiled by the Georgia Coalition Against Domestic Violence from its news clipping service and from reporting domestic violence agencies statewide. This count represents all the domestic violence-related deaths known to us at the time of this report.

Statistics include primary victims, secondary victims and alleged perpetrators. Of the 118 deaths in 2007, 77 were primary victims, 14 were secondary victims, and 27 were alleged perpetrators. Primary victims include intimate partners and former intimate partners of the alleged perpetrators. Secondary victims include family, friends, new intimate partners, children, and other bystanders who were killed by the alleged perpetrator. Most alleged perpetrators who died committed suicide after killing or attempting to kill the victim(s). Alleged perpetrators are included to show the full scope of loss of life due to domestic violence.

This chart only includes counties in which a domestic violence homicide was known to have occurred between 2003 and 2007. Any changes from previously published data reflect inclusion of the most recent fatality information.

Domestic Violence Deaths in Georgia by County: 2003 through 2007

| County of Fatality | total annual deaths | | | | |
|---|---|---|---|---|---|
| | '07 | '06 | '05 | '04 | '03 |
| Appling | | 4 | | | |
| Baldwin | 1 | 3 | 3 | | |
| Barrow | | | 1 | 1 | 1 |
| Bartow | 1 | | 2 | | 4 |
| Ben Hill | 2 | | | 2 | 1 |
| Berrien | 1 | | | | |
| Bibb | 6 | 2 | 6 | 4 | 1 |
| Bleckley | | | 2 | | |
| Brantley | | | | 1 | |
| Bulloch | | 1 | | | |
| Burke | | | | 1 | 2 |
| Butts | 2 | | | | 1 |
| Calhoun | 1 | | | | 3 |
| Camden | | | 1 | 1 | 1 |
| Carroll | 1 | 2 | | 1 | 1 |
| Catoosa | 1 | | | | |
| Chatham | 2 | 3 | 8 | 2 | 6 |
| Cherokee | 3 | | 4 | 1 | 1 |
| Clarke | 1 | 2 | 2 | | 3 |
| Clayton | 7 | 11 | 10 | 3 | 3 |
| Cobb | 5 | 11 | 8 | 3 | 6 |
| Coffee | 1 | | 1 | | |
| Colquitt | 1 | | 3 | | 3 |
| Columbia | | | 2 | | 1 |
| Cook | 1 | 2 | | | |
| Coweta | 2 | | | 1 | |
| Crisp | 1 | | 1 | | 2 |
| Dawson | | | 1 | | |
| Dekalb | 7 | 8 | 3 | 5 | 17 |
| Dodge | | 1 | | | |
| Dooly | | | | 1 | |
| Dougherty | 2 | 1 | | 2 | 1 |
| Douglas | | | | 1 | 1 |
| Effingham | | 1 | | | |

| County of Fatality | total annual deaths | | | | |
|---|---|---|---|---|---|
| | '07 | '06 | '05 | '04 | '03 |
| Elbert | | | 1 | | 1 |
| Fannin | 2 | | 1 | | 1 |
| Fayette | 3 | 1 | | 4 | |
| Floyd | 1 | 1 | 1 | 2 | 1 |
| Forsyth | | 2 | | | 4 |
| Franklin | | | | 1 | |
| Fulton | 10 | 4 | 7 | 15 | 10 |
| Gilmer | | | 1 | | |
| Glascock | | | 1 | | |
| Glynn | 2 | 1 | | | 2 |
| Gordon | 1 | 1 | | 4 | |
| Grady | 1 | | | | 1 |
| Gwinnett | 7 | 12 | 12 | 12 | 6 |
| Habersham | | | | | 1 |
| Hall | 3 | 2 | | 2 | |
| Hancock | | | | 1 | |
| Haralson | | | | | 4 |
| Harris | | | 2 | 1 | |
| Henry | | 4 | 3 | 1 | 3 |
| Houston | | 1 | 2 | | 1 |
| Jackson | | 6 | 1 | 2 | |
| Jefferson | | 2 | | | 2 |
| Jenkins | 1 | 1 | | | |
| Lamar | | | 2 | | |
| Laurens | | 1 | 1 | 2 | 2 |
| Lee | 2 | | | | |
| Liberty | | 6 | | | 4 |
| Lowndes | | | 9 | 1 | |
| Lumpkin | | | | 1 | |
| Macon | | | 1 | | |
| Madison | | | | | 2 |
| McDuffie | | | | 2 | 1 |
| Monroe | | 1 | | | |
| Montgomery | | | | | 1 |

| County of Fatality | total annual deaths | | | | |
|---|---|---|---|---|---|
| | '07 | '06 | '05 | '04 | '03 |
| Muscogee | 5 | 1 | 9 | | 3 |
| Newton | 4 | 3 | | 1 | 3 |
| Oconee | | | | 1 | |
| Oglethorpe | | | | | 1 |
| Paulding | | | | 2 | 1 |
| Pickens | 1 | | 1 | | |
| Polk | 2 | | | 2 | 1 |
| Richmond | 4 | 1 | 2 | 6 | 4 |
| Rockdale | 1 | | 3 | 4 | |
| Schley | 1 | | | | |
| Screven | | 1 | | | |
| Seminole | | 1 | | | |
| Spalding | 3 | | | | |
| Tattnall | | | | 2 | 1 |
| Telfair | | 1 | 3 | | |
| Thomas | 2 | | | 1 | |
| Tift | 5 | | 1 | | |
| Towns | | | | 2 | |
| Troup | 1 | | | | 1 |
| Twiggs | | | | 1 | |
| Upson | | | | 1 | 2 |
| Walker | 1 | | 2 | | |
| Walton | | | | 2 | |
| Ware | 1 | | 1 | | |
| Warren | 1 | | | | |
| Washington | | | 1 | | 1 |
| Wayne | 3 | | | | 4 |
| Webster | | | | | 1 |
| Wheeler | | | | | 1 |
| White | | | | 1 | 2 |
| Whitfield | | | 1 | 3 | 2 |
| Worth | 1 | | | | |
| Undisclosed | | | | | 3 |
| YEAR | '07 | '06 | '05 | '04 | '03 |
| TOTAL DEATHS | 118 | 106 | 127 | 110 | 137 |

*"If the numbers we see in domestic violence were applied to terrorism or gang violence, the entire country would be up in arms, and it would be the lead story on the news every night."*

*-Rep. Mark Green, U.S. Congress*

*The Georgia Commission on Family Violence (GCFV) and the Georgia Coalition Against Domestic Violence (GCADV) are grateful to the many individuals who continue to make Georgia's Fatality Review Project possible.*

# *acknowledgements*


### *Fatality Review Project Staff*

**Greg Loughlin**, Co-Coordinator, Fatality Review Project, GCFV

**Taylor Thompson**, Co-Coordinator, Fatality Review Project, GCADV

**Kirsten Rambo**, Executive Director, GCFV

**Beck Dunn**, Executive Director, GCADV

For part of the current project year, **Jasmine Williams Miller** staffed the project for GCFV.

### *The Georgia Coalition Against Domestic Violence*

(GCADV) is a state coalition of 53 organizations and individuals 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 survivors and their children through a number of initiatives including the Fatality Review Project, a Transitional Housing project, and a Legal Assistance project. Finally, GCADV advocates for improvements in systems responding to survivors and offenders through public policy and legislative advocacy. Please visit *www.gcadv.org* or call 404-209-0280 for more information.

### *The Georgia Commission on Family Violence*

(GCFV) is a Commission under the Governor's Office, administratively attached to the Department of Corrections. GCFV 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 sets certification standards for Family Violence Intervention Programs (FVIPs) in Georgia and provides training and technical assistance to FVIPs and task forces. GCFV also hosts an annual statewide conference on domestic violence. Please visit *www.gcfv.org* or call 404-657-3412 for more information.

### *Special Thanks*

A special acknowledgement goes to the **family members and friends** of homicide victims who were willing to share with us the struggles their loved ones faced.

Our special thanks go to the **survivors of the near fatality incidents** who allowed us to learn from their experiences.

Thank you to **Shelley Senterfitt**, Attorney at Law, who provided legal research and counsel for the project.

We are especially grateful to **Allison Smith, GCADV**, who again conducted data analysis for the project, allowing us to provide aggregate data for this report.

We are also grateful for technical assistance from the **National Domestic Violence Fatality Review Initiative**. We are particularly thankful for their support in allowing us to receive strategic planning assistance and training from **Robin H. Thompson**.

Our appreciation goes to the **Washington State Coalition Against Domestic Violence** for their ongoing guidance and technical assistance. Our efforts have benefited greatly from the groundbreaking work done by Washington review teams, under the leadership of their Coalition staff.

Our special thanks to **Debbie Lillard, MSW, LCSW**, Mosaic Counseling, Inc., and **Rebecca Lentz**, **LPC,** who assisted with the near fatality interviews.

### *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 conducting fatality reviews.

In-kind donations of time and skill in the design, production and printing of this annual report were provided by **Nancy Dickinson**, MSW candidate, Alpharetta, GA and **Canterbury Press LLC**, Atlanta, GA.

### *Fatality Review Project Advisory Committee*

Many thanks are due 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:

**Mr. Dick Bathrick**
Men Stopping Violence

**Lt. Col. Maureen Carter**
Retired, USAR

**Ms. Cynthia Hinrichs Clanton**
Administrative Office of the Courts

**Ms. Lisa Dawson**
Division of Public Health

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State Board of Pardons and Paroles

**Ms. Kris Jones**
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Fulton County Solicitor General

**Ms. Paula P. Smith**
Prosecuting Attorneys' Council of Georgia

**Deputy Sheriff Chris Storey**
Clayton County Sheriff's Department

**Ms. Lori Trull**
Georgia Probation Management

### *Review Teams*

We acknowledge the commitment of the Fatality Review Team participants from around the state who devoted their time, energy, and expertise to work towards creating safer communities. Several of the communities that participated in the project this year have been participating for the last four years. This presented a challenge for some in identifying a case for review since they had exhausted their eligible pool of fatality cases. Teams unable to identify a case for review instead focused their efforts on implementing past recommendations.

#### *Atlanta Judicial Circuit*

**Laura Barton**, Partnership Against Domestic Violence
**Deborah Espy**, District Attorney's Office
**Lisa H. Geer**, Families First
**Nicole Lesser**, District Attorney's Office
**Wendy Lipshutz**, Jewish Family & Career Services
**Sheri Miller**, Odyssey Family Counseling Center
**Jodi Mount**, Atlanta Legal Aid Society
**Amanda Planchard**, Solicitor General's Office
**Nicole Rubin**, Jewish Family & Career Services
**Dr. Michele Stauffenberg**, Fulton County Medical Examiner

#### *Blue Ridge Judicial Circuit*

**Tommie DeGonzague**, Cherokee Family Violence Center
**Amy Fowler**, Cherokee County DFCS
**Kay Kreft**, Solicitor General's Office
**Niki Lemeshka**, Cherokee Family Violence Center
**Carrie McCurdy**, Solicitor General's Office
**Rebekah Shelnutt**, Solicitor General's Office
**Sgt. David Simmons**, Sheriff's Office
**Lori Trull**, Georgia Probation Management
**Chastity Warren**, Georgia Probation Management

#### *Chattahoochee Judicial Circuit*

**Kyle Bair**, Sexual Assault Support Center
**Linda Bass**, Muscogee County Schools
**A.E. Davis**, Columbus Police Department
**Rhonda Dunlap**, Solicitor General's Office
**Valencia Evans**, Hope Harbour
**Mattie Hall**, Urban League
**Shelly Hall**, Victim Witness Program
**Sally Haskins**, Georgia Legal Services Program
**Jacy Jenkins**, Hope Harbour
**Mary Leverett**, Hope Harbour
**Pam Maney**, Discovery Toys
**Rachel Snipes**, The Family Center

#### *Conasauga Judicial Circuit*

**Lynne Cabe**, Dalton State College
**Steve DeCostanzo**, Whitfield County DFCS
**Laura Head**, District Attorney's Office
**Betty Higgins**, Northwest Georgia Family Crisis Center, Inc.
**Sue Jordan**, Northwest Georgia Family Crisis Center, Inc.
**Kermit McManus**, District Attorney
**Jim Sneary**, The RESOLV Project
**Glenn Swinney**, District Attorney's Office

***Eastern Judicial Circuit***
**Judge James Bass**, Superior Court, Chatham County
**Reverend Matthew S. Brown Jr.**, First Union Baptist Church
**Sharon Carson**, Chatham County DFCS
**Jennifer P. Guyer**, District Attorney's Office
**David Lock**, District Attorney's Office
**Isabel Pauley**, District Attorney's Office
**Frank Pennington II**, District Attorney's Office
**Rose Grant-Robinson**, S.A.F.E. Shelter Outreach
**Kenya White**, State Probation
**Joe Williams**, State Probation
**Yukeyveaya Wright**, District Attorney's Office

***Gwinnett Judicial Circuit***
**Reinette Arnold**, Partnership Against Domestic Violence
**Penelope Batts**, Awake, Inc.
**Jennifer Hope**, Atlanta Family Counseling Center
**Sgt. Tracy Lee**, Gwinnett County Sheriff's Department
**Mike Leonard**, District Attorney's Office
**Julie Mauney**, Community Volunteer
**Michelle Toledo**, Partnership Against Domestic Violence
**Lynda Waggoner**, Community Volunteer

***Stone Mountain Judicial Circuit***
**Lt. Billi Akins**, DeKalb County Sheriff's Department
**Judge Berryl A. Anderson**, Magistrate Court
**Erica Barnes**, DeKalb County DFCS
**Dick Bathrick**, Men Stopping Violence
**Kevin Batye**, DeKalb State Court Probation
**Sgt. Jay Eisner**, DeKalb County Police Department
**Gwen Keyes Fleming**, District Attorney's Office
**Kim Frndak**, Women's Resource Center
**Dewanda Jackson**, MLC Counseling Services
**LeRoya Jennings**, Solicitor General's Office
**Betsy Ramsey**, Solicitor General's Office
**Ingrid Skidmore**, District Attorney's Office
**Sandra Williams**, Atlanta Intervention Network

# *executive summary*

In the past five years, almost 600 Georgians have lost their lives to domestic violence.[1] Georgia has the unfortunate distinction of being ranked 14th in the nation for the rate at which men kill women in single-victim homicides, most of which are domestic violence murders.[2] And too often, when these murders are committed, children are either injured, killed, or witness to the violent death of their beloved parent or caregiver.

The project described in these pages is a response to the tragedy of domestic violence deaths in Georgia. Begun in 2004, Georgia's Domestic Violence Fatality Review Project seeks to learn from these deaths and work toward preventing future loss of life. In communities across the state, individuals working as volunteers gather to share information and examine these cases in detail. Through this process, they are able to identify those gaps in prevention or response that may have contributed to the tragedy. Having then identified which of those elements may be ongoing problems in their community, they are able to make informed recommendations and determine action steps for improving those systems in the future.

At the state level, the staff of the Fatality Review Project collects the information gathered by these community teams, called Fatality Review Teams. After aggregating the data and identifying common themes, the results are compiled and published in this Annual Report. While the fatality review findings contained in this report emerge directly from Fatality Review Teams, the recommendations and analysis contained here are the product of deliberations and discussion by Georgia Coalition Against Domestic Violence and Georgia Commission on Family Violence staff. Information in this report does not necessarily represent the opinions of individual Fatality Review Team or Advisory Committee members.

### *Reviewed Cases: 2004-2008*
Of the 65 cases reviewed in five years, there were a total of 89 fatalities. These included

63 intimate partner victims
19 alleged perpetrators
3 children of the intimate partner victim
2 sisters of the intimate partner victim
1 new partner of the intimate partner victim
1 aunt of the intimate partner victim.

There were 5 unsuccessful murder attempts on

1 intimate partner victim
1 sister of the intimate partner victim

[1] Statistics compiled by the Georgia Coalition Against Domestic Violence from its clipping service and from reporting domestic violence agencies statewide show that 598 Georgians lost their lives to domestic violence from 2003-2007. This count represents all the homicides known to us for that time period at the time of this report.

[2] "When Men Murder Women: An Analysis of 2006 Homicide Data." Violence Policy Center, September 2008.

1 brother of the intimate partner victim
1 mother of the intimate partner victim
1 new partner of the intimate partner victim.

There were also 2 individuals who were wounded during the commission of the intimate partner homicide, including

1 child of the intimate partner victim
1 family member of the intimate partner victim.

Of the 63 intimate partner fatalities,

35 were caused by firearms
16 were caused by stabbing or laceration
6 were caused by strangulation
5 were caused by blunt force trauma
1 was caused by asphyxiation due to smoke inhalation.

### *About this Report*

It is important to note that this report is not meant to replace any of the Project's previous reports. Instead, this report only adds to and builds upon the findings, recommendations, conclusions, and resources contained in the prior reports. For example, as this is the fifth year of the project, most of the data in the "Data" section is, unless otherwise noted, five-year aggregate data that captures all of the fatalities reviewed since the Project's inception. In addition, several aspects of this year's report represent a change from those of previous years:

- **Expanded "Near Fatalities" Section:** This Report contains the results of interviews with two survivors of near-fatal attacks. Both of these in-depth interviews yielded tremendous insight into the problem of domestic violence, as well as important assessments of various interventions. This year's expanded "Near Fatalities" section includes accounts of these two cases. It also features detailed analysis of the insights gleaned from these interviews and common themes that emerged among all four of the near-fatality interviews conducted over the course of the project.

- **Increased Focus on Informal Support Networks:**
  - Each year, the reviews of fatalities and near-fatalities suggest that people experiencing domestic violence tend to turn primarily to informal networks for support: their friends, family members, neighbors, coworkers, employers, and faith communities. At the same time, those systems that are equipped to provide resources to survivors and accountability for batterers – such as domestic violence agencies and law enforcement – are not generally the first places that survivors turn to. The section entitled, "Disclosing Domestic Violence: Where Survivors Go and Why" begins a discussion about this complicated reality and what it might mean for those of us who work in professional roles.
  - The "Insight from Friends and Family" section explores what we have learned over five years of interviewing family and friends about the loss of their loved ones. This section reminds us of the humanity of the people who lost their lives and of the grief that lives on for their surviving family and friends. As we encourage professionals to be more intentional about engaging and educating family and friends, this section calls us to never forget the ongoing sense of loss that family members and friends experience at the death of their loved ones. It is this reminder of personal grief and loss that should renew our sense of urgency and commitment to ending domestic violence in our communities.
  - Given the importance of informal support networks to survivors, we have also included a section called "What You Can Do if You Know Someone Who is Being Abused or Who is Abusing." Previous reports have included similar information, but this year we have included this section as a tear-off page to encourage readers to actively distribute it to others in their communities. This section seeks to better equip those groups who typically have the most comprehensive and current information about the violence (family, friends, clergy, coworkers, etc.) to respond in ways that will be most beneficial to survivors.

- **Highlighting New Ideas:**
  - Previous reports have encouraged communities to implement changes based on Fatality Review findings and recommendations. In this report, we spotlight three innovative initiatives – two from Georgia, one from Maryland - that provide examples of implementation. First, given the significance of faith communities in the lives of so many victims and abusers in reviewed cases, we have highlighted a faith-based domestic violence training hosted by the Conasauga Judicial Circuit in Dalton, GA. We have also highlighted the Western Judicial Circuit's fatality review process as a model for how a community can recruit key people to the table, sustain momentum for fatality review over an extended period of time, and proactively implement system changes based on review findings. Finally, we highlight a Maryland initiative that is successfully training law enforcement officers to conduct lethality assessments on the scene of domestic violence calls, and, in high-risk cases, immediately connect the survivor to the domestic violence hotline. We hope that these examples provide inspiration for other Georgia communities to make changes based on what they have learned through Fatality Review.
  - Last year's report included a "Findings and Recommendations" section that reflected a comprehensive list of the major findings and recommendations of the Project to date. Because that section encompassed so many of the basic

themes from previous years, this year's report does not repeat that section. Instead, this report's "New Findings and Recommendations" section includes only recommendations that emerged from cases that were reviewed in 2008 and were not included in the 2007 report.

- Finally, the "Broadening the Scope" section challenges Fatality Review Teams to think in new ways about what may constitute a domestic violence death. In particular, we challenge teams to consider reviewing domestic violence-related victim suicides and HIV/AIDS-related deaths.

❖ **User-Friendly Format:** Responding to requests from readers, we are placing this report online in a format that allows users to download individual charts and sections. We intend this format to enable readers to use specific information contained in this report as needed to bolster the training and community education that they are conducting to stop domestic violence in Georgia. Please go to ***www.fatalityreview.com*** to access the report by section.

We hope that you will find this report to be thought-provoking, informative, and inspiring, and we hope that you will use it to create change within your community. If you have suggestions about how we can improve this report to make it even more useful to you, please do not hesitate to contact us with your ideas.

***A Note about Language***

Throughout the report, we use both the terms "victim" and "survivor." We have chosen to use "victim" either to describe a person who has been killed or when differentiating between the perpetrator and the victim of different types of abuse. We use "survivor" to describe a person who is currently suffering or has suffered abuse, but is alive. We have chosen this language deliberately for several reasons: first, most who survive this kind of abuse do not identify as victims of domestic violence; we have found that many are often more comfortable identifying as survivors. Second, the term "survivor" is appropriate as it honors the fact that those who, regardless of what stage of escape they are in, are employing survival strategies on a daily basis as they try to keep themselves and their children safe from abuse. In addition, we use the term "domestic violence agency" as opposed to "shelter." By referring to themselves as "shelters," these agencies may inadvertently be creating barriers to people seeking their services. Since they provide a range of services such as free support groups, childcare, safety planning, legal assistance, and other services, referring to these agencies as "shelters" may limit some people's understanding of what services they can actually provide. Additionally, some survivors who are not seeking shelter, or who have concerns due to their beliefs about the desirability of living in a shelter, may be reluctant to seek help from these programs if they believe that they only provide shelter.

**The Fatality Review Project is federally funded** by the Violence Against Women Act (VAWA) 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 lead and assist Fatality Review Teams across the state in conducting homicide reviews and implementing the resulting findings and recommendations. The Fatality Review Advisory Committee, consisting of leaders from various systems across the state, meets quarterly to provide support and direction to the project.

# *mission statement*

*The Georgia Domestic Violence 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 near-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.*

*"There is absolutely no inevitability as long as there is a willingness to contemplate what is happening."*

*- Marshall McLuhan*

***Committee Formation***
The Family Violence Task Force in each participating community formed a multi-disciplinary Fatality Review Team to function as a subcommittee of the local Family Violence Task Force. Representatives from the following systems are invited to join the teams: community and prosecution-based advocates, corrections, prosecution, judicial, law enforcement, Family Violence Intervention Programs, Department of Family and Children's Services, faith, mental health, alcohol and drug counseling, and schools.

***Case Selection***
The Teams select domestic violence-related homicide cases for review with three criteria in mind:

- All civil and criminal proceedings related to the victim and the perpetrator have been closed with no pending appeals
- The perpetrator has been identified by the criminal justice system
- When possible, the date of the homicide does not extend beyond 3-5 years.

Homicides are 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 are also considered domestic violence-related.

***Case Information Collection***
Once the cases are selected, the Team gathers all public records pertaining to the case. The majority of the information is located in the prosecutor's file and/or the homicide file. Only information that can be obtained pursuant to the Open Records Act is collected.

***Family & Friend Interviews***
When applicable and appropriate, the Project Coordinators seek out interviews with surviving family and friends of the victim, who in turn provide incredible insight not gleaned from the public documents. The discussions are open-ended, with family members and friends being invited to share what they want the Team to know about their loved one, the steps the victim took to try to be safe, and the victim's perceptions of the options available in the community.

***Case Chronology Development***
A chronology for each case is developed by the Project Coordinator with a focus on all prior significant events leading up to the death. These include prior acts of violence perpetrated by the person who committed the homicide (whether against this victim or another), previous attempts by the victim to seek help, previous criminal and civil history, etc. A completed chronology is distributed to each Team member.

***Fatality Reviews***
The Teams, after signing a confidentiality statement, having a moment of silence for the victim(s), and conducting an oral reading of the chronology, go 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, each Team identifies gaps in local response, areas where practice did not 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***
The Teams then make findings about the factors in each case that appeared to contribute to the death, or conversely, actions which, if taken, might have prevented the death. Teams are always focused on reviewing the systems' response: what types of resources were available in each system for victims and offenders, what the policy and protocol for response were, whether they were followed or not, and what monitoring, training and accountability existed in each system for workers who responded to families. From the findings, each Team makes recommendations about changes to systems that would improve victim safety and offender accountability.

***Data Analysis***
Data is entered into an electronic database designed for this project and adapted from the work of data collection tools used around the country. The data is then aggregated and comprises the data findings in this report.

In this current report, the sum of individual data fields may not total 100% due to rounding.

For more detailed information regarding the methodology of the Georgia Fatality Review Project, please see pages 10-11 in our 2005 Annual Report.

# data

Chart 1: Gender, Employment, and Income, 2004-2008

| CHARACTERISTICS | Victim | | Perpetrator | |
|---|---|---|---|---|
| | Number | % | Number | % |
| **Gender** | | | | |
| Female* | 63 | 97% | 2 | 3% |
| Male | 2 | 3% | 63 | 97% |
| **Employment Status** | | | | |
| Employed | 47 | 72% | 40 | 62% |
| Employed full-time | 33 | 51% | 30 | 46% |
| Employed part-time | 5 | 8% | 4 | 6% |
| Employed, unsure if full-time or part-time | 5 | 8% | 2 | 3% |
| Self-employed | 3 | 5% | 4 | 6% |
| Employed part-time and student | 1 | 2% | 0 | 0% |
| Unemployed | 7 | 11% | 9 | 14% |
| Retired | 2 | 3% | 1 | 2% |
| Disabled | 1 | 2% | 1 | 2% |
| Unemployed student | 1 | 2% | 1 | 2% |
| Unknown | 7 | 11% | 13 | 20% |
| **Sources of Financial Support** | | | | |
| Personal wages | 46 | 71% | 39 | 60% |
| No personal income, reliant on perpetrator for financial support | 3 | 5% | 0 | 0% |
| SSI / SSDI | 2 | 4% | 0 | 0% |
| Personal wages and family support | 2 | 3% | 0 | 0% |
| Family support | 1 | 2% | 1 | 2% |
| Family support, WIC, and Food Stamps | 1 | 2% | 1 | 2% |
| No income, unknown source of support | 1 | 2% | 2 | 3% |
| Personal wages and alimony | 1 | 2% | 0 | 0% |
| Drug dealing | 0 | 0% | 2 | 3% |
| No personal income, reliant on victim for financial support | 0 | 0% | 7 | 11% |
| Retirement pension | 0 | 0% | 1 | 2% |
| Unknown | 8 | 12% | 12 | 18% |

*Note: One female perpetrator killed a male partner; one killed a female partner. One male perpetrator killed a male partner. All remaining homicides were men killing women.

Chart 1: Key Points:

- In line with national statistics, the overwhelming number of homicide victims in reviewed cases were women; the overwhelming number of perpetrators were men.
- Note that the majority of perpetrators and victims were employed, suggesting that employers and coworkers have a role to play in ending the violence.

Chart 2: Types of Incidents, 2004-2008

| TYPES OF INCIDENTS | Aggregate % for 2004-2008 |
|---|---|
| Single Victim | 55% |
| Homicide + Suicide | 18% |
| Homicide + Attempted Suicide | 6% |
| Homicide + Suicide + Attempted Homicide of Others | 5% |
| Multiple Homicide + Suicide | 5% |
| Homicide + Attempted Homicide of Others | 3% |
| Multiple Homicide | 3% |
| Homicide + Suicide + Others Wounded | 2% |
| Multiple Homicide + Attempted Homicide of Others + Others Wounded | 2% |
| Victim Suicide | 2% |
| | |
| Incidents Involving Perpetrator Suicide or Attempted Suicide | 35% |
| Incidents Involving Homicide of Others, Attempted Homicide of Others, or Others Wounded | 18% |

Chart 2: Key Points:

- In 35% of the cases reviewed, the perpetrator attempted or completed suicide in addition to killing or attempting to kill one or more persons. This finding indicates a significant correlation between domestic violence perpetrators' suicidal thoughts or threats and their danger to others.
- In 18% of the cases reviewed, the perpetrator killed, attempted to kill, or injured someone other than the primary victim. Perpetrators do not limit their violence to their intimate partner. Often, other people close to the primary victim are targeted either because they are with the primary victim at the time of the attack or because the perpetrator intends to cause additional anguish to the primary victim by harming her friends or loved ones.

Chart 3: Cause of Death, 2004-2008

| CAUSE OF DEATH | Aggregate % for 2004-2008 |
|---|---|
| Gunshot | 54% |
| Stab wounds / Stab wounds and lacerations | 25% |
| Strangulation | 12% |
| Blunt or sharp force trauma | 6% |
| Asphyxiation due to smoke inhalation | 2% |
| Multiple traumatic injuries | 2% |

Chart 3: Key Point:

- Firearms continue to be the leading cause of death for victims in reviewed cases - greater than all other methods combined - indicating the urgent need to use all legal means possible to remove firearms from the hands of abusers.

Chart 4: Who Else Was Present, a Witness to, or Killed at the Fatality, 2004-2008

| WHO ELSE WAS PRESENT? | Present | | Witnessed | | Killed | |
|---|---|---|---|---|---|---|
| | % of total 2004-2008 cases | Actual number of people | % of total 2004-2008 cases | Actual number of people | % of total 2004-2008 cases | Actual number of people |
| **TOTAL** | **72%** | **105** | **35%** | **77** | **6%** | **6** |
| Children | 45% | 55 | 17% | 39 | 5% | 3 |
| Family members | 18% | 19 | 5% | 11 | 3% | 2 |
| Friends | 5% | 3 | 3% | 2 | 0% | 0 |
| New intimate partners | 3% | 2 | 2% | 1 | 2% | 1 |
| Coworkers | 2% | 1 | 0% | 0 | 0% | 0 |
| Acquaintances or neighbors | 6% | 6 | 6% | 5 | 0% | 0 |
| Strangers | 6% | 19 | 6% | 19 | 0% | 0 |

Chart 4:

For the purpose of this chart, individuals labeled as “present” are those who were in the same area where the homicide occurred but did not hear or see the homicide. Those individuals who did have a sensory experience of the homicide have been determined to have “witnessed” the homicide.

Key Points:

- Contrary to popular understandings of domestic violence as a “private” issue, it is often the case that people other than the victim and the perpetrator are present at, witness to, or killed during a domestic violence homicide. The violence often spills over to affect family, friends, and bystanders. 2004-2008 data indicate that in 72% of reviewed cases, someone was present at the scene of the fatality. 35% of the time, someone witnessed the homicide. In 6% of reviewed cases, someone other than the primary victim was killed.

- In 17% of reviewed cases, children witnessed the homicide. This finding suggests that there is a critical need to assist children in dealing with the traumatic effects of witnessing the homicide of a loved one.

Chart 5: Perpetrators' History as Known by the Community, 2004-2008

| PERPETRATORS' BEHAVIOR | | Percentage of cases where this factor was present | WHO WAS AWARE? | | | | |
|---|---|---|---|---|---|---|---|
| | | | Family and friends | Law enforcement | Criminal courts | Civil courts | Service providers |
| Violent or criminal behavior | History of DV against victim | 88% | 68% | 60% | 19% | 21% | 30% |
| | Threats to kill primary victim | 57% | 54% | 41% | 16% | 27% | 19% |
| | Violent criminal history | 57% | 43% | 86% | 32% | 11% | 27% |
| | Threats to harm victim with weapon | 43% | 54% | 39% | 18% | 7% | 18% |
| | Stalking | 43% | 54% | 36% | 11% | 4% | 14% |
| | Child abuse perpetrator* | 35% | 36% | 50% | 29% | 36% | 36% |
| | History of DV against others* | 30% | 58% | 58% | 33% | 17% | 8% |
| | Sexual abuse perpetrator | 26% | 47% | 35% | 0% | 24% | 12% |
| | Inflicted serious injury on victim* | 25% | 100% | 50% | 40% | 0% | 20% |
| | Strangulation | 20% | 38% | 38% | 23% | 0% | 8% |
| | Threats to kill children, family, and/ or friends* | 20% | 63% | 50% | 25% | 25% | 13% |
| | Harmed victim with weapon* | 15% | 67% | 67% | 50% | 0% | 33% |
| | Hostage taking* | 10% | 75% | 50% | 50% | 25% | 50% |
| Controlling behavior | Monitoring and controlling | 54% | 71% | 11% | 0% | 6% | 14% |
| | Isolation of victim* | 35% | 86% | 0% | 0% | 7% | 7% |
| | Ownership of victim* | 20% | 100% | 0% | 0% | 0% | 13% |
| Mental health issues and substance abuse | Alcohol and drug abuse | 51% | 64% | 58% | 15% | 15% | 30% |
| | Suicide threats and attempts | 38% | 52% | 24% | 8% | 4% | 32% |
| | Depression* | 28% | 64% | 27% | 18% | 9% | 55% |

*Note: Asterisks indicate only 2005-2008 data. There were a total of 40 cases during those years, so the denominator changes in the calculation of the percentage.

Chart 5:

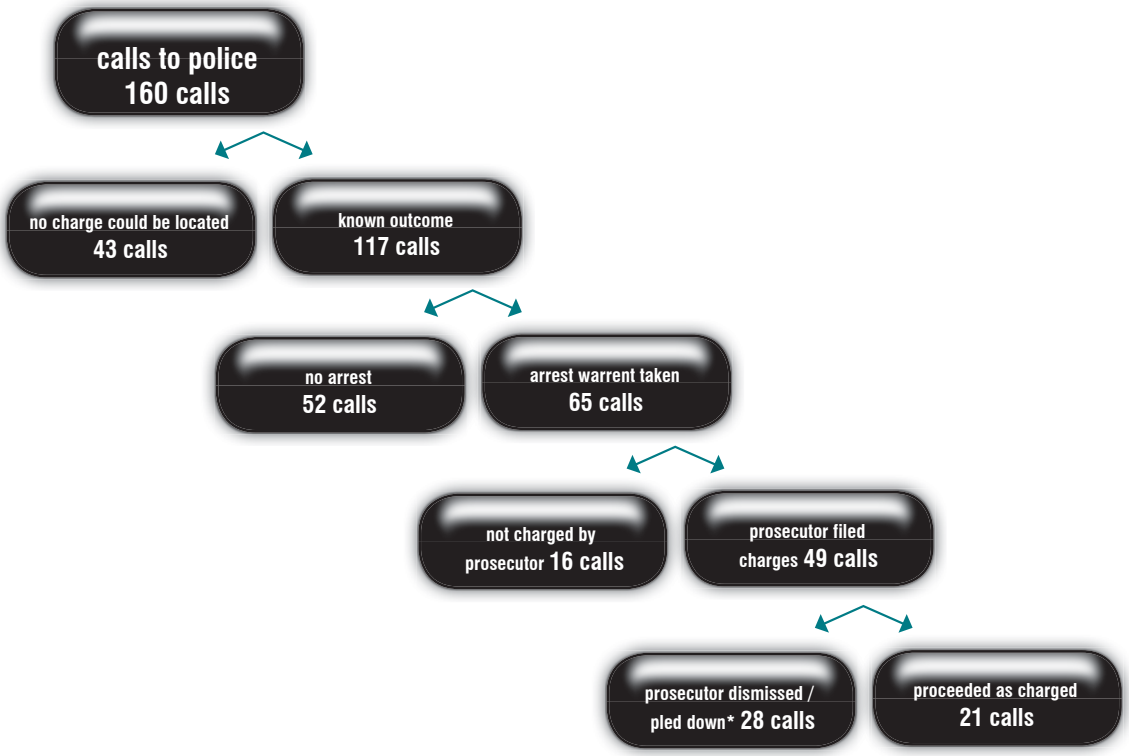
Information for this chart was gathered primarily through available protective order petitions, police reports, prosecutor files, homicide investigations, and interviews with family and friends. Project Coordinators then categorized these behaviors based on commonly used guidelines for lethality indicators. Conclusions about who knew what information were based on the source of the information.

Here is an example of how this chart may be read: "In cases where monitoring and controlling behaviors were present, family and friends knew about this in 71% of those cases."

Key Points:

- These numbers reveal that family and friends of the victim generally know the most information about the relationship.
- In cases where the perpetrator had inflicted serious injury on the victim, family and friends were aware of this fact 100% of the time, yet law enforcement was only aware of this fact 50% of the time. These numbers remind us that law enforcement often has limited information about the relationship. They also reinforce how knowledgeable friends and family are about the abuse.
- In 88% of the cases, the perpetrator had a history of some domestic violence against the victim prior to the homicide. This suggests that a good indicator of future and possibly lethal violence is the presence of past violence. This history was not always known to the criminal justice system.
- In only 25% of the cases did the perpetrator inflict serious injury on the victim in an incident prior to the homicide. This suggests that while serious or visible injury is a predictor of future and possibly lethal violence, it will not always be present in cases where victims are later killed.

Chart 6: Detail of Investigation and Prosecution Breakdown, 2004-2008




* Note: The "dismissed/pled down" category includes cases that were dismissed because the victim was killed prior to the case proceeding to prosecution.

Chart 6: Key Points:

- A review of the case histories reveals that calling law enforcement does not always result in increased safety, justice, or perpetrator accountability. In those cases where law enforcement was called and the outcome is known, only 42% were charged by the prosecutor, and more than half of those were subsequently either dismissed or pled down.

- When law enforcement was called to the scene, 59% of the time no arrest warrant was taken or no evidence of a charge could be located. This percentage includes cases where the law enforcement officer did not take a warrant because the perpetrator had left the scene. It also includes cases where the perpetrator remained on the scene and the officer advised the victim to take the warrant herself. **These practices send a message to the victim that the crime committed against her is not being taken seriously by the criminal justice system. Additionally, they send the message to perpetrators that the criminal justice system will not hold them accountable for their behavior.**

Chart 7: Key Points:

- Of all agencies and services, law enforcement had the most contact with both victims and perpetrators prior to the homicide, indicating the need for continued law enforcement training on the dynamics of domestic violence and where to refer domestic violence victims for services.
- Only 18% of homicide victims were in contact with the domestic violence shelter or safehouse in the five years prior to their death. Additional outreach is needed to make people aware of helping resources. It is also likely that some of these victims knew about available services and chose not to access them. Some of the reasons survivors have given for not seeking shelter include the stigma that surrounds entering a shelter, and their belief that shelters are undesirable places to stay. This suggests that domestic violence agencies need to take proactive steps to ensure that their services are accessible, culturally relevant, and inviting to domestic violence victims.
- A significant number of perpetrators and victims were engaged with a church, temple or mosque, suggesting that faith communities have a role to play in ending the violence.

Chart 7: Agencies and Services Involved with Victim or Perpetrator in the Five Years Prior to the Fatality, 2004-2008

| AGENCY / SERVICE / PROGRAM | | VICTIMS | | PERPETRATORS | |
|---|---|---|---|---|---|
| | | Number | % total cases | Number | % total cases |
| Justice System Agencies | Law enforcement | 50 | 77% | 54 | 83% |
| | County prosecutor | 25 | 38% | 32 | 49% |
| | Superior court | 21 | 32% | 25 | 38% |
| | Magistrate court | 18 | 28% | 24 | 37% |
| | State court | 14 | 22% | 11 | 17% |
| | Civil divorce court | 13 | 20% | 13 | 20% |
| | Protection order advocacy program | 11 | 17% | 1 | 2% |
| | Court-based legal advocacy | 10 | 15% | 2 | 3% |
| | Probation | 6 | 9% | 24 | 37% |
| | Legal aid | 4 | 6% | 0 | 0% |
| | Municipal court | 3 | 5% | 9 | 14% |
| | Parole | 1 | 2% | 6 | 9% |
| | City prosecutor | 1 | 2% | 5 | 8% |
| Social Service Agencies | Child protective services (DFCS) | 7 | 11% | 7 | 11% |
| | Child care services | 4 | 6% | 2 | 3% |
| | TANF or Food Stamps | 2 | 3% | 1 | 2% |
| | Homeless shelter | 2 | 3% | 1 | 2% |
| | WIC | 2 | 3% | 0 | 0% |
| Health Care Agencies | Hospital care | 12 | 18% | 12 | 18% |
| | Emergency medical service (EMS) | 11 | 17% | 5 | 8% |
| | Private physician | 9 | 14% | 9 | 14% |
| | Emergency medical care | 9 | 14% | 3 | 5% |
| | Mental health provider | 7 | 11% | 12 | 18% |
| | Medicaid | 3 | 5% | 0 | 0% |
| | Substance abuse program | 2 | 3% | 2 | 3% |
| | PeachCare | 1 | 2% | 0 | 0% |
| Family Violence Agencies | Community-based advocacy | 13 | 20% | 4 | 6% |
| | Domestic violence shelter or safehouse | 12 | 18% | 0 | 0% |
| | Family violence intervention program (FVIP) | 1 | 2% | 10 | 15% |
| | Sexual assault program | 1 | 2% | 0 | 0% |
| Miscellaneous Agencies | Religious community, church, temple, or mosque | 16 | 25% | 11 | 17% |
| | Immigrant resettlement | 2 | 3% | 1 | 2% |
| | English as Second Language (ESL) program | 1 | 2% | 0 | 0% |
| | Anger management | 0 | 0% | 5 | 8% |

# *brief case narratives*

The following table briefly describes each case reviewed in 2008. Sentencing data sources are Prosecutors' files, the Georgia Department of Corrections, and Fatality Review Teams. Sentences may reflect the fact that many of the perpetrators in reviewed cases had prior contact with the police and courts.

| *Brief Narratives Of Each Fatality* | *Sentence Imposed* |
|---|---|
| ***Case 1:*** After a long history of violence, DV perpetrator shot DV victim multiple times before calling the police and turning himself in. In the weeks before her death, DV victim told several friends that she wanted to leave her husband and that she was afraid because he had threatened to kill her. She told one friend, "If I stay, he will kill me. If I leave, he will kill me." DV perpetrator was stalking the victim and adamantly accusing her of having an affair. | Perpetrator was found guilty of malice murder, felony murder and aggravated assault. He was sentenced to life in prison. |
| ***Case 2:*** DV victim committed suicide after a long history of failed system intervention. DV perpetrator had been arrested multiple times with numerous different charges, including simple battery, terroristic threats, driving violations, simple assault FVA, failure to appear in court, and trafficking methamphetamine. DV victim filed several TPOs that were violated by the DV perpetrator. During his last stint in jail prior to her death, DV perpetrator sent her a letter threatening that he would be out of jail soon and he could be her friend or her enemy. | The victim committed suicide. |
| ***Case 3:*** After a year-long dating relationship, DV perpetrator killed the DV victim by hitting her in the head with a hammer and strangling her. DV victim was in the process of breaking up with the DV perpetrator and moving out of their apartment. DV victim told family and friends about the DV perpetrator's physical abuse of her, stalking, and statements that he could not live without her. Law enforcement was never involved prior to the homicide. | Perpetrator was found guilty of murder and is serving a life sentence. |
| ***Case 4:*** After twenty years of marriage, DV perpetrator shot the DV victim three times, left the residence, and shot himself in the head. DV perpetrator had a long history of substance abuse and escalating violence towards the DV victim. DV perpetrator had been stalking the DV victim, threatening suicide, and threatening to kill the DV victim. One month before the shooting, the DV perpetrator held the DV victim hostage in the bathroom, held a gun to her head, and beat her for six hours. DV victim had recently obtained a TPO and filed for divorce. | Perpetrator committed suicide. The victim survived the shooting. |
| ***Case 5:*** After a two and a half year relationship, DV perpetrator stabbed the DV victim to death after she told him that she did not want to be in a relationship with him anymore. DV perpetrator and DV victim were periodically homeless and lived together at a rooming house at the time of the attack. Neighbors at the rooming house were aware of the abuse and frequently called law enforcement. DV perpetrator had been arrested multiple times for domestic violence towards the DV victim. On one of these occasions she had a visible head wound. | Perpetrator convicted of voluntary manslaughter and sentenced to 20 years in prison. |
| ***Case 6:*** After suffering physical and emotional abuse and isolation during one and a half years of marriage, DV victim separated from the DV perpetrator, obtained a TPO, and filed for divorce. While the TPO was in effect, the DV perpetrator lay in wait outside the marital residence and approached the DV victim and their baby son as she left for work in the early morning hours. As she turned to flee, he shot the DV victim three times and their son once. The victim and their son survived the attack. The perpetrator was already a convicted felon for shooting two men in the back. | The perpetrator was convicted of two counts of aggravated assault, aggravated stalking, cruelty to children, and possession of a firearm in committing a crime. Perpetrator was sentenced to 35 years in prison. |

# *near fatalities: narratives and emerging themes*

For a third year, the Fatality Review Project has interviewed victims of domestic violence who survived near-fatal attacks on their lives at the hands of their intimate partners. This process provides a safe forum for survivors to offer feedback to communities and systems about their near-fatal experiences. It is an opportunity for us, as a community, to hear from domestic violence survivors and learn ways of better serving them by listening to and learning from their personal stories.

Case selection for near fatalities is based on specific criteria and utilizes a system of interviewing that includes a licensed therapist, a support person chosen by the survivor, a note taker, and an interviewer. Our key guiding principal in this process is to remain survivor-centered and to fully explore all areas of need she might have that are particularly related to safety and support resources. Detailed information about the case selection process can be found in the Near Fatality section of the 2006 Georgia Domestic Violence Fatality Review Annual Report.

As in previous years, these interviews have yielded invaluable information. We share the stories of these two survivors with the belief that we all have much to learn by listening to the experiences of women who have survived near-fatal attacks.



## ***Sylvia's** Story**

Sylvia is a 37-year-old mother of two. Sylvia and the perpetrator, Robert, were married for about a year and a half before the attempted homicide. Sylvia and Robert are parents of a 5 year-old son, Marcus. Sylvia also has a 15-year-old daughter, Kim, from a previous relationship.

Sylvia and Robert met through family members; Robert went to high school with Sylvia's sister. Robert was charming, and he and Sylvia quickly developed a relationship. Later, Sylvia learned that Robert had been in prison and was still on probation. Robert told her that he was in prison for shooting somebody in self-defense who was trying to rob him. By that time, Sylvia said, she had already developed feelings for Robert, and the relationship continued.

When they met, Sylvia was an independent woman with a good job at a government benefits office and owned her own house and car. Her family lived nearby, and she described her family and coworkers as a good support system. Robert had recently been released from prison and was living with his mother. He was self-employed sporadically as a vehicle upholsterer and a low-voltage electrician, and was a minister in training at his church. As their relationship developed, Robert moved in with Sylvia and they were later married.

### *Isolation*

Even before the marriage, Robert tried to isolate Sylvia from friends and family. This theme of isolation continued throughout Sylvia's relationship to Robert and manifested itself in many ways:

- Robert would get into fights with Sylvia's family members, making it uncomfortable for them to see each other. When Sylvia was seven months pregnant, Robert got into a fight with Sylvia's sister who was visiting. Sylvia's sister and Robert were arrested in a dual arrest. The charges were later dropped against both of them. Sylvia felt such stress from the fight that she had to go to the hospital and thought she was having the baby. She missed her sister's wedding because of the tension between her sister and Robert. This isolation from family was particularly painful for Sylvia, because she is very close to her family.

- Robert isolated Sylvia from her faith community. Sylvia grew up in a church that her family attended, but after they were married Robert wanted them to go to his family's church. Leaving her home church was just one of the many ways that Sylvia now understands Robert was attempting to isolate her from her family and support systems.

- Robert pressured Sylvia to quit her job. Sylvia describes her work as an important source of support for herself, and she refused to give it up. Also, Robert was only working sporadically and she knew that they could not survive economically without her job.

- Robert began interfering with visitation between Sylvia's daughter Kim and Kim's father. He did not want the father to have contact with Sylvia or Kim. Robert also became increasingly resentful of Kim. Sylvia says that Robert wanted to narrow down their world so that it included just Sylvia, Robert, and, after he was born, their son Marcus.

- Later in the relationship, Robert began monitoring Sylvia's activities closely. He installed cameras around the house so that he could watch her. She also discovered that he had installed a tape recorder in her car. Sylvia felt scared by Robert's monitoring of her activities.

**All names used in this section are pseudonyms*

*She asked, "Who could I tell and not compromise our safety?"*

Robert's attempts to isolate Sylvia were done mainly in private. She describes him as putting up a good front so no one knew about the abuse. Sylvia said she knew at the time that Robert had issues, but she thought he would change. Also, Sylvia describes not recognizing Robert's actions as abusive at the time. "When you're in that situation, you don't see it," she says.

### Physical Abuse

After Sylvia and Robert were married, Robert began to physically abuse Sylvia. Sylvia remembers the shock of the first time Robert hit her, giving her a black eye. Sylvia had never been in an abusive relationship before, and she felt ashamed. Sylvia's daughter Kim was present at the incident. After that, the physical abuse became more frequent, but Robert would hit Sylvia in places where bruises would not be seen. He would also blame her for the abuse, saying "You made me do it!" Sylvia says that at the time no one knew about the abuse other than her daughter.

Eventually, Sylvia would fight back when Robert assaulted her. Neighbors called the police several times due to noise. However, no arrests were made, and no police reports were filed. Sylvia did not call the police herself. She was pregnant by then and did not want Robert to go back to prison. She was also afraid of what Robert would do if she did call the police.

Sylvia had her baby son and the abuse continued. Robert hit Sylvia in the eye while she was out on maternity leave and coworkers would not see her black eye. As the abuse continued, Sylvia said that she lost confidence in herself and felt very isolated. "I didn't feel like I could go to anybody," she said, "They wouldn't understand. I stopped caring about everything except the children. The main thing that kept me going was my kids."

### Hiding the Abuse

Sylvia's daughter began to tell people about the abuse. After Robert broke a mirror, scaring her, Kim told a school counselor. When the counselor called Sylvia, Sylvia made up an excuse for the violence and said that the mirror had accidentally fallen. The counselor did not pursue the issue any further. "I knew how to do a façade," Sylvia says. Sylvia also chastised Kim for telling someone outside of the family about the abuse. Sylvia says that she did not feel good about keeping up this façade or chastising her daughter. She was doing what she thought she needed to do to protect her daughter and herself from Robert.

Sylvia's desire to keep the abuse secret and not tell the school counselor, police, and her family, friends, and coworkers is informative. She asked, "Who could I tell and not compromise our safety?" Sylvia knew that she was living with a highly dangerous man, and she believed that anyone she would tell would try to intervene. She believed those attempts would be insufficient to stop Robert's violence and that she and her children would be in greater danger. She knew that she would have to be prepared for Robert's increased violence when people did intervene. She also wondered what she would have to do to keep her family safe when she did decide to make that move: where would she go? Robert had already threatened to hurt her family if she left him. Sylvia said, "There were too many things I had to think about. I wasn't quick to make a move." So Sylvia did her best to keep the abuse hidden from others until she was ready. Instead, she said, "I didn't tell anybody until after I got out."

To endure the abuse and live with the fear and danger she was facing, Sylvia often rationalized and minimized Robert's behavior. "That's not happening to me," Sylvia would say to herself. As she observes now, "I was in denial." Still, there were moments when she had to acknowledge to herself that her relationship was not working. Over time, she began to get "fed up."

### Losing Custody

In addition to the school counselor, Kim also told her father about the abuse. In response, Kim's father complained to law enforcement about the abuse his daughter was witnessing. Law enforcement reported the abuse to Child Protective Services (CPS), which opened up an investigation. During the investigation, CPS interviewed Kim but did not interview Sylvia. No further action was taken by CPS.

Kim's father also filed for custody of her based upon the domestic violence that was present in her home. During the custody hearing, Sylvia learned that Robert had previously been in prison for shooting two men in the back – not for self-defense, as he had told her. The court granted the petition, and Sylvia's daughter was removed from her custody. Despite the fact that Sylvia's daughter was removed from her custody based on the domestic violence Robert was committing, neither her civil attorney nor the court referred Sylvia to the local domestic violence agency for safety planning or support. Sylvia was devastated by the loss of custody, but Robert was happy. He sent Sylvia flowers at work. Losing her daughter was one of the moments when Sylvia says she realized something needed to change.

### Family Intervention

To see Kim, Sylvia had to have visitation at her mother's house, which gave her an opportunity to reconnect with her family. On Father's Day weekend, Sylvia took Marcus to her mother's house so that they could be with Kim for the weekend. Robert had wanted Sylvia to leave their son with him, but intuitively, she refused. Sylvia had not disclosed the abuse to her mother, but her mother knew that something was wrong. Her mother said, "You are not going anywhere," and told Sylvia and her son to stay with her. Sylvia found her mother's intervention to be extremely helpful and supportive. She believes that if she

*Sylvia says, "Something opened up in my mind. I realized that I was being abused."*

had gone back to Robert that weekend, he would have killed her. She stayed with her mother for several weeks. Being away from Robert, Sylvia says, "Something opened up in my mind. I realized that I was being abused."

While she was with her mother, Sylvia's sister also tried to intervene. Her sister told her that if she went back to Robert, she would not speak to her again. Although her sister was trying to protect her, Sylvia did not find this response to be helpful, because it only limited her options as she struggled to make difficult choices.

After Sylvia left, Robert began to make promises to persuade her to come back. He also came over to her mother's house to talk with her mother. When these tactics did not work, Robert called the police and said that Sylvia's mother was holding his son hostage. When the police came to the house, an officer asked Sylvia if Robert was hurting her. This was her first encounter with the police where an officer asked her about domestic violence. Sylvia still was not ready to talk with the police about the abuse and said no. The police took no further action.



### Church Response

Sylvia's mother called her church and asked for help for her daughter. Even though Sylvia had been attending Robert's church, her mother's church remembered Sylvia and was extremely supportive to her. Her mother's church sent people to meet with Sylvia, and they referred her to the local domestic violence agency. Sylvia also remembers that the church placed domestic violence information in its bathroom stalls.

Sylvia had experienced a different response when she sought help from the church she attended with Robert. Shortly after losing custody of her daughter, Sylvia remembers going with Robert to talk with their pastor. The pastor was mentoring Robert and knew about some of Robert's past violence towards others. However, Sylvia describes the pastor as giving Robert "chance after chance" to reform. The pastor told Sylvia, "You probably won't get your daughter back." Sylvia felt very depressed by this response and she did not find it to be helpful. "I wanted encouragement," she said. The pastor did not separate Robert and Sylvia to speak with them, nor did he inquire about Robert's violence that caused her to lose custody of her daughter. Also, Sylvia felt that Robert was close to the pastor, and she did not feel safe talking with him about the abuse.

### Reaching Out to the Domestic Violence Agency

As Sylvia's strength grew during her separation, she decided that she wanted to divorce Robert. She approached the domestic violence agency's outreach center and asked for help in obtaining a divorce. During this interaction, the domestic violence advocate did not conduct any safety planning or lethality assessment with her. The advocate told her that they had a long waiting list and that it would be a year before they could help her. Sylvia decided to hire her own attorney and filed for divorce. She then approached the domestic violence agency again and asked for help in obtaining a temporary protective order (TPO). This time, Sylvia spoke with another advocate, whom she describes as being very supportive. This advocate provided Sylvia with a good education about what a TPO is and how it might enable her to move back into her house. She also gave Sylvia pamphlets about domestic violence and talked with her about changing her locks and getting flood lights. Nonetheless, the advocate told her that the domestic violence agency could not help her with filing a TPO because she had already hired an attorney for the divorce and that her divorce attorney should help her. Sylvia did not receive a lethality assessment or in-depth safety planning from these advocates during either of her interactions with them. She did, however, receive a referral to a local mental health counselor, whom she found to be very helpful. Still, the minimal safety planning and lack of a lethality assessment loom large in the events that followed.

### Moving Back Home

Sylvia paid her private attorney to help her obtain a TPO against Robert. The same judge that handled the custody hearing and divorce handled the TPO hearing. Sylvia found it to be very helpful for the same judge to hear all three proceedings because the judge was familiar with the domestic violence she had suffered when he heard the TPO petition. The *ex parte* TPO was granted, and Sylvia was awarded possession of her house. Robert was forced to vacate the home, and Sylvia and her son moved back in. During her absence, Robert had taken out the TV, carpet, and some of her clothing. He also damaged much of the house, and she had to clean it up. Still, Sylvia said that it felt peaceful to be back at home with her child. At some level, however, Sylvia knew that she could be in danger. She promptly changed the locks and installed an alarm.

### The Attack

Robert had become increasingly and publicly agitated after Sylvia left. Sylvia said that he could no longer keep up the façade that everything was fine. A friend and fellow church member called Sylvia and told her that when people in church asked Robert where Sylvia was, Robert became angry. Robert was telling people that Sylvia had left him. The friend told Sylvia that even she was becoming afraid of Robert because of his volatile reactions.

One week before the final TPO hearing was scheduled, Robert waited in a rented car near Sylvia's house. At about 6:20 am, as Sylvia took their son to her car to go to work, Robert drove up and blocked their driveway. He got out of the car with a gun, and Sylvia ran to a neighbor's yard with Marcus in her arms. Robert shot Sylvia three times and Marcus – who was 13 months old at the time

– once. Sylvia was shot in the upper right arm, upper left thigh, and the back of the neck. Marcus's left leg was broken by a bullet and surgery was required to repair it. Robert fled as neighbors came to Sylvia and Marcus's aid.

After she was released from the hospital, Sylvia took Marcus to the shelter of the local domestic violence agency to hide while the police looked for Robert. While Sylvia appreciated the safety of the shelter, she was frustrated by the rigidity of the shelter rules. For example, clients were told when they could and could not watch television. Sylvia was also required to attend a house meeting on the day after she had been shot. This was a hard adjustment for her to make after she had been living in her own home. Sylvia worries that such rigid rules may discourage other women from using the shelter.

Robert was apprehended three days later. He pled not guilty, and a jury found him guilty of two counts of Aggravated Assault, Aggravated Stalking, Cruelty to Children, and Possession of a Firearm in Committing a Crime. Robert was sentenced to serve 35 years in prison followed by 40 years of probation.

### *Recovery*

Sylvia and her son have fully recovered from their injuries and are now thriving. Sylvia has regained custody of her daughter and now lives with Kim and Marcus in her own home. She continues to work for the government benefits office where she has worked for the past 11 years. Sylvia is engaged in a new relationship, and she is pursuing her bachelor's degree. She does public speaking for the local domestic violence agency, and she eventually would like to work in the field of domestic violence. Sylvia finds strength in telling her story. "It gives me strength to give other people strength," she says.

## *Lori's Story*

Lori is a 44-year-old mother of two. Lori and the perpetrator, Steven, were married for 23 years before Steven attempted to kill Lori by shooting her three times. He then killed himself. Lori and Steven's son, Bill, was 15, and their daughter, Ellen, was 12 at the time of the shooting.

### *Substance Abuse and Violence*

From the beginning of their relationship, Steven would drink a lot and use cocaine and crystal methamphetamine. After Lori protested about his drug use, he switched to frequent marijuana and alcohol abuse. He was also jealous and violent very early in their relationship. Lori said, "I was always fearful that he would snap my neck in a drunken rage." Despite her fear, Lori stayed with Steven because she loved him, they had children together, and the financial costs of divorce were too high. Steven was determined that he was not going to be like his father – an abusive alcoholic. But, according to Lori, the more stridently he tried not to be like his dad, the more he became like him. Steven's substance abuse and violence escalated over the course of their marriage.

*Lori remembers one of her coworkers telling her, "This is scary -- this is not normal!"*

In Lori's view, the substance abuse caused the physical and emotional abuse; she and others primarily focused on the need for Steven to stop drinking and using drugs. She went to Al-Anon meetings to see how she could support Steven in this way. Steven and she also saw a therapist together a few times, and then they arranged to see the therapist separately. Steven refused to go, so Lori only saw the therapist a few more times. The therapy was expensive, and Lori did not feel like it would help if only she went and Steven did not. During those sessions, Lori and the therapist discussed Steven's substance abuse problem, not the violence. Lori also reached out to Steven's brothers for help regarding Steven's substance abuse. Lori said that at that point Steven's brothers and mother were aware of Steven's violence. Lori said she received no help from Steven's family.

The first time Steven abused her when he was sober, Lori reached a turning point in the relationship. One day, in Steven's home office, Lori noticed a check that needed to be deposited. Lori often supported Steven's business dealings and did his accounting books for him. After a few days of waiting, Lori told Steven that she would take the check to the bank herself. Steven became enraged and started to threaten Lori with a baseball bat. "He went to crazyland!" Lori said, "And he was sober!" Lori said she began to realize that Steven's abuse might not have been connected to his substance abuse. She said she was also beginning to internalize an important lesson that she learned from Al-Anon – that she could not fix Steven. She could not fix his substance abuse, and she could not fix his violence.

For most of the marriage, Lori supported Steven's home-based business. However, three years before the homicide attempt, Lori decided to take a job outside of the home. Lori wanted to get away from the abuse and also force Steven to take more responsibility. Lori felt that he had too much free time enabling him to engage in substance abuse, and that it would be good for him to work harder on the business. By the time Lori began working outside of the home, Steven's mother had begun living with them, and his mother performed some of the support duties that Lori had previously done. Because of this, Steven still had free time available to drink and use marijuana.

### *Support from Friends and Coworkers*

Lori's outside employment gave her time to connect with other people and gain some of the support that she needed. Lori did not confide in her family about the abuse, but she did talk to friends about it. Lori said that her coworkers and friends provided her with a reality

*Lori always feared that Steven's threat of committing suicide would become a reality.*

check: they helped her understand that she was in danger. One day, when Lori was with coworkers, Steven showed up, banging on the window and accusing her of infidelity. Afterwards, one of the coworkers told Lori, "This is scary -- this is not normal!" On another occasion, a female friend spent the night at Lori's house. Steven yelled at Lori throughout the night. The friend later told Lori that she had been so scared that she had slept with her cell phone in her hand in case she needed to call the police. Lori's boss was also concerned about her safety and told her about temporary protective orders. Lori found it particularly helpful to have friends who told her, "This is not normal," and asked her, "Do you want to live this way?" Lori said, "In my mind, at the time, the abuse seemed so normal." She said it was very helpful to her to have friends and coworkers tell her otherwise.

### Considering Divorce

One year before the shooting, Lori asked Steven for a divorce. When she consulted a lawyer, the lawyer said that the divorce would cost $10,000 for her and $10,000 for Steven. The lawyer also said her son was old enough to choose who he would live with. The cost and the possibility that her son might end up living with Steven were major barriers for Lori and kept her from moving forward with the divorce. Financial concerns loomed large for Lori as she considered getting out of the relationship; Steven and Lori were in a lot of debt. Lori knew that "once you get separated, you're in poverty." Without Lori present to do the accounting for Steven's business, she knew that money would not be coming in, and she would no longer be able to count on his business for support. It took time for Lori to resign herself to the possibility of poverty and the idea that she and her kids would need to survive without much money when they left Steven.

During the period when she asked for a divorce, Lori also had a brief affair with a coworker. When Lori was scared to go home, she would sometimes spend the night with female coworkers. On a couple of occasions, she went home with a male coworker and "things went too far." This only happened a couple of times before Lori ended it. After she had the affair, Lori went to live with her mother for three days. She felt guilty about the affair, however, and she went back to live with Steven. Lori was fairly certain that Steven was having affairs as well, because he would leave the house and not come back for days. Steven found out about Lori's affair about a month after it ended as Lori attempted to get some property back from the man and Steven was monitoring her cell phone calls.

### Suicide Threats

Lori always feared that Steven's threat of committing suicide would become a reality. Ten years before Steven attempted to kill her, Lori remembers getting the kids in the van and preparing to leave Steven. As she did, she had a horrible feeling that Steven would kill himself. In her mind's eye, she could see him take his gun out and put it to his head. She felt it. Lori took the kids back home because of this feeling. Steven had not threatened or attempted suicide at this point. Instead, Lori's intuition told her that Steven might commit suicide.

Lori's intuition proved to be accurate. After Lori asked for a divorce and took steps to separate from Steven, he began making frequent and explicit suicide threats. He would call Lori's cell phone and leave detailed messages about how and where he was going to kill himself. He also threatened her and left messages with gunshots recorded on her phone. Sometimes Steven would call her repeatedly for six hours straight, leaving messages on her cell phone. The messages became so frequent that Lori would turn off her cell phone. Steven was also calling his family during this time and threatening suicide. According to Lori, they stopped taking his calls, too.

### Escalating Violence

Lori described the three years before the attack as "the hell years." "I remember lots of choking," Lori says. Steven would also suffocate Lori with a pillow. Even now, Lori says, "When I'm in bed, don't put a pillow near me." In addition, Steven began stalking Lori. He would show up at her workplace and call her friends, saying "Where is the bitch?" Lori began hiding her friends' phone numbers, and she made sure that Steven did not know where her friends lived.

About a month before the shooting, Steven held Lori hostage for six hours in the bathroom of their home. He held a gun to her head and beat her with a billy club. Steven's mother was home at the time and saw what was happening. She did not intervene. Instead, she took the children away from the house. Lori felt betrayed and hurt that Steven's mother did not intervene. Lori asked her mother-in-law to move out of the house shortly after the incident.

### Law Enforcement Response

Lori called the police immediately after the bathroom incident and the police responded to the scene. Steven had already left. Despite her report of the abuse she suffered, the police asked Lori if she wanted to press charges. They did not take out the warrant themselves, but instead put the burden on Lori to do so. Lori did not want to further antagonize Steven, and she was doubtful that she would be safe after pressing charges, so she did not.

Law enforcement left Lori to take out her own warrant on another occasion as well. Lori and Steven were at her cousin's house for a Christmas party. Steven became very drunk and broke out the glass in the cousin's door. Then, he wanted to drive away and leave the party. Lori had the keys and would not give them to him because she did not want him to drive drunk. Steven knocked Lori down and began hitting and kicking her to get the keys. The cousin called the police and Steven went to one of the bedrooms and passed out. The police responded to the scene but

*Lori was never connected to an advocate during the TPO process.*

did not take action in response to the violence that had just occurred. Instead, they asked Lori if she wanted to press charges. Lori was scared to press charges herself because it would aggravate Steven, and she believed that it would cost her more money. Lori said that she wishes that the police had taken out the warrants themselves and had not placed the burden on her. To pursue criminal prosecution herself would increase, rather than decrease, her danger.

Previously, Lori had had another negative experience with police. Steven was at home drunk and Lori feared that he would become violent. Lori wanted to go home to pick up some clothes so that she could go somewhere else. She approached some police officers and asked them if they would escort her home to retrieve her clothes safely. The officers would not do it. "It's ok for him to be drunk in his own home," they said. Lori feels bitter about this: why wouldn't the police help her with such a simple request?

### *Valentine's Day*

Events escalated on Valentine's Day, which was also Lori and Steven's anniversary. Things had been going reasonably well between them, Lori said, as they discussed options for separating. They were cooperating and looking for an apartment for Lori. Despite their plans to separate, Lori and Steven agreed to have dinner on their anniversary. On her way home from work, however, Steven called Lori and she could tell that he was really drunk. Something told Lori that she should not go home that night, so she went to a hotel instead. While at the hotel, Lori called a friend. She remembers her friend asking her, "Do you really want to live like this?"

When Lori did not come home, Steven left a series of threatening messages on her cell phone. Then, the messages abruptly stopped. Lori learned later that the messages stopped because Steven had been pulled over for a DUI. She found out much later that Steven also had a gun in the car. She now believes that he was driving around looking for her and the man that she had had the affair with. She believes that he wanted to kill them that night.

Steven's life was deteriorating quickly. This was his third or fourth DUI, which meant he would lose his license and thus, his business – and he was already in a lot of debt. Also, he had developed diabetes and early signs of cirrhosis of the liver due to his drinking. Lori also believes that Steven was taking Xanax and over-the-counter sleep medicines. Steven's life was on a downward spiral, and he knew it.

### *Protective Order and Divorce*

The day after Valentine's Day, while Steven was still in jail for the DUI, Lori got an *ex parte* TPO. Lori filled out the paperwork herself and was awarded temporary possession of the house and custody of the two children. Steven was served with the order in jail. Despite the fact that Lori notified the court about Steven's threats to kill her, his suicidal threats, stalking, and that he had held her at gunpoint and beaten her with a billy club, no one in the courthouse referred her to the local domestic violence agency for additional safety planning and support.

Lori was never connected to an advocate during the TPO process. She strongly believes that women should be educated about domestic violence and offered safety planning while seeking TPOs. According to Lori, some women may not fully realize how much danger they are in at that point, but they do know that something is not right and that they need help. "I did not even know myself," Lori said. "I was seeking sanity in my day to day life. I didn't know he was going to kill me. You don't really think you're in jeopardy."

While the *ex parte* TPO was in effect, Lori hired an attorney to help her with the second TPO hearing and to help her get a divorce. Lori's boss was a friend of the attorney, and he kept telling the attorney that Lori's situation with Steven was dangerous and that he should take the case very seriously. Eight days later, Lori and Steven attended the second TPO hearing. The TPO was entered by consent agreement. Instead of ordering Steven, as the violent party, to stay away from Lori, the order restrained both parties from harassing the other. Again, no one at the courthouse referred Lori to the local domestic violence agency. Furthermore, rather than ordering Steven to immediately surrender his firearms to the sheriff's office, the order required Steven "to provide to the Court proof that such items have been delivered to a third party." This more informal mechanism for gun removal, with no deadline attached, left Steven with too much leeway regarding to whom he gave the guns and when. It also left the court with little basis for enforcement of this provision. Furthermore, it sent the message that the court was not serious about removing Steven's firearms.

The TPO also granted Steven liberal contact with Lori, allowing him contact with her and access to their house for work purposes during daylight business hours. It also provided for unsupervised exchange of the children at their home. Lori's attorney warned her that this was too lenient, and that she should fight to not have any contact with Steven. Lori appreciated how seriously her attorney took the situation and how his warning helped her understand more about the danger that she was experiencing. Still, Lori did not want to deprive her children of access to their father, and she consented to the TPO that allowed Steven to have some access to her and the kids.

### *The Attack*

The same day Lori and Steven got the protective order by consent, Steven came by their house after midnight. Their son and daughter were asleep. When he came to the door, Lori could tell that something was not right. Steven

was not drunk, which was unusual. He was just different. Lori sensed his extreme sadness, but she did not feel threatened at all: Steven had consented to the protective order and had recently agreed to a quick and easy divorce. Looking back later, Lori understood that Steven was agreeing to everything because he knew it did not matter: he had already made up his mind to attack her and kill himself. But she did not know that at the time. At the door, Steven said, "I love you." Lori said that they could talk in the morning, and she shut the door.

Steven burst through the door and into the house and shot Lori in the side of the head, the neck, and the finger. A fourth shot hit the fax machine. Lori still doesn't know if Steven thought that she was fatally wounded or not. Steven was a hunter and a good shot. Despite her wounds, Lori was able to get up, go to the phone, and call 911. While she was on the line with 911, Steven put the gun to his head and pulled the trigger. Nothing happened. He pulled the trigger again, and again, nothing happened. He then went to the safe to get more bullets and left. He went over to the friend's house where he had been staying after the protective order forced him to move out of the house. Steven called Lori's cell phone and left a message: "What am I supposed to do now?" Then he shot and killed himself on his friend's porch. Lori had always believed that she would sense it somehow if Steven hurt himself. But when he did, she did not feel anything.

Faith played an important role in helping Lori deal with the attack. Lori believes that angels intervened on her behalf that night, causing the gun to misfire and preventing Steven from killing himself at their home. She believes that angels kept her children asleep while the attack happened. Lori also said that she felt no pain from the gunshots, and that angels kept her from feeling pain. Her faith clearly played a key role in her ability to survive the attack, and it was important to Lori that people know about this aspect of her experience.

### *Recovery*

After the shooting, Lori was plunged deep into debt. "I was instantly drowning," she said. No one connected her to any helping resources, and no one told her about victims' compensation options. She told her story to investigators, but she could not afford therapy for herself or her children to talk about what happened to them. Lori wonders how these events have affected her children. Her daughter will talk about Steven and the abuse, but her son will not. Lori worries about how he is coping with it all. Lori and her children are still struggling with debt and the emotional toll of what happened. They are strong, but they are struggling to put their lives back together.

# *emerging themes*

### *Importance of Informal Support Networks*

While law enforcement and the criminal justice system eventually became involved in both of these cases, the survivors themselves seemed to have relied more heavily on informal support networks. Family, friends, neighbors, coworkers, and clergy all became aware of the abuse in one or both of these cases and had opportunities to take action to support the survivor and hold the abuser accountable. These informal supports seem to have played a big role in helping the survivors recognize that something was wrong and that they were in danger. Lori's friends told her, "Something is wrong; this is not normal," while Sylvia's mother recognized that something was not right and persuaded Sylvia to stay with her and not go back to Robert.

When functioning at their best, these informal supports served as a reality check for the survivor – validating her experience, supporting her efforts to get safe, and connecting her to other resources. For example, Sylvia's faith community referred her to the local domestic violence agency, while Lori's boss told her about temporary protective orders. Still, family, friends, neighbors, coworkers and clergy need more information and skills in order to be able to offer support and refer survivors to existing resources, particularly the local domestic violence agency for safety planning. It is meaningful that, out of all the interaction Lori and Sylvia had with family, friends, neighbors, coworkers and clergy, only Sylvia's faith community seems to have referred her to the local domestic violence agency for support. Family and friends also need to be trained in how to support a survivor without threatening to withdraw support if she makes a decision with which they do not agree. Domestic violence agencies need to find ways to market their services to family, friends, neighbors and coworkers, and to offer support to those individuals when they call. Domestic violence agencies also need to market their services so that informal support networks are aware that these organizations offer more than shelter, and that survivors as well as family, friends, and coworkers can call for a confidential sounding board and help with safety planning and support.

### *Inconsistent Law Enforcement Response*

In the near fatality cases we studied in the two previous reports, neither woman sought help from the criminal justice system. In this year's cases, however, both women had contact with law enforcement prior to the homicide attempts. Law enforcement became involved in each of these cases, but on many occasions they took no action when action would have been appropriate. For Sylvia, law enforcement responded multiple times, but they took no action, did not provide her with information about the domestic violence hotline, and did not write up police reports of the incidents. Subsequently, when Sylvia took

steps to separate from her abuser, she felt that some providers did not fully appreciate the danger she was in because she did not have police reports documenting the abuse. Despite the absence of police reports, Sylvia was in considerable danger. Law enforcement should write reports for each incident of domestic violence to which they respond.

Law enforcement should also take out warrants themselves when an act of family violence has occurred. In Lori's case, police responded to the scene on at least two occasions after Steven had abused Lori. In each of these instances, law enforcement put the onus on Lori to take out a warrant for Steven's arrest. Lori did not feel safe taking out the warrants herself. She wishes law enforcement had taken out the warrants themselves and taken steps to arrest Steven. When probable cause exists and law enforcement does not arrest or take out a warrant, it sends the message to the victim, the perpetrator, and the community that the violence is not taken seriously.

For both of these women, contact with law enforcement was their first contact with a helping profession. Law enforcement has a vital role to play, and unfortunately, in both these cases, they sent the exact wrong messages to the victim about their willingness to intervene and to the perpetrator about their willingness to hold him accountable. Law enforcement should recognize the potential lethality of domestic violence cases and take appropriate action when responding to calls, including writing police reports after each call and taking out warrants when appropriate.

### *Importance of Advocacy During the TPO Process*

When they were ready to seek formal help, both Lori and Sylvia turned to the temporary protective order process for safety. Both Lori and Sylvia accessed private attorneys to help them with their TPOs. Neither attorney referred the woman to the local domestic violence agency for safety planning and lethality assessment. Civil attorneys and court personnel must be educated about the need to refer domestic violence victims to existing services.

Because of a referral from her church, Sylvia was connected to a domestic violence advocate during the TPO process; Lori was not. In Sylvia's experience, the domestic violence agency was helpful, but they did not engage with her in in-depth safety planning or lethality assessment. Sylvia knew that she was in some danger, but in-depth safety planning and lethality assessment could have helped her understand the full scope of the danger she was facing. Domestic violence agencies should actively take steps to engage in safety planning and lethality assessment with every woman they come into contact with, regardless of perceived need. Lori was never connected to an advocate during the TPO process. Reflecting on her case, she believes strongly that all women seeking TPOs need access to an advocate during the process, because it can be a time of great danger, which an advocate can help women identify and better understand. Domestic violence agencies and funding sources need to find ways to maximize women's access to advocates during the TPO process.

### *Limited Support after the Attack*

Lori received little support from advocates after she was shot. She had never been connected to a domestic violence agency, and since Steven committed suicide, eliminating prosecution proceedings, she had never been connected to a victim witness advocate either. She was never informed about victims' compensation, and she was even left to clean up the crime scene by herself. She was plunged deep into debt after the shooting and desperately needed victims' compensation, but she never learned about it. Lori also wanted her family to go to counseling after the shooting, but she could not afford it. Victim's compensation could have helped with that, as well. Even when there is no prosecution, law enforcement and advocates must fully inform domestic violence survivors of their rights to victim compensation and other services after such an attack.

### *Focus on Substance Abuse*

Although the issue of substance abuse emerged in only one of the two near-fatality interviews that we conducted this year, it has surfaced in many other reviewed cases and bears some discussion here. In Lori's case, Steven's substance abuse generated a lot of attention from both informal and formal systems. Lori went to Al-Anon meetings and called Steven's family for help with his substance abuse. She also went to counseling and talked with the therapist about Steven's substance abuse. Law enforcement became involved in Steven's substance abuse through his multiple DUIs. Clearly, Steven's substance abuse needed to be addressed, but the focus on his drinking and drug use also distracted Lori and others from the critical issue of Steven's escalating violence. For example, when Lori approached police officers and asked them to escort her home so that she could get her clothes safely, the officers focused on the substance abuse and not the violence by saying that Steven had a right to be drunk in his own home. In essence, the substance abuse masked the violence and distracted the officers' attention from it. Law enforcement officers, advocates, the courts, and service providers should screen for violence and take steps to address it, even when substance abuse is the presenting problem.

# *risk factors:*

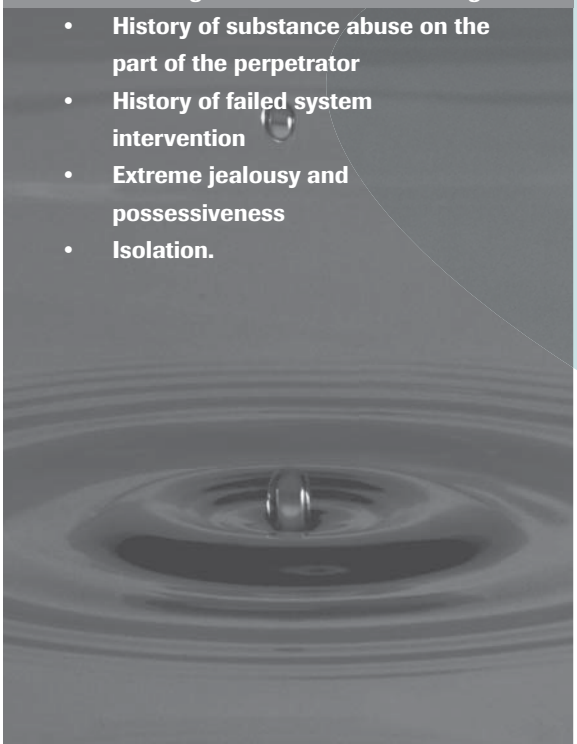
**Throughout the interviews with Lori and Sylvia, factors emerged that indicated their increased risk for homicide, including the following:**

**For Sylvia:**

- **Recent separation**
- **History of abuse**
- **Stalking and monitoring behavior**
- **Perpetrator's previous felony convictions for violent offenses**
- **Isolation**
- **History of failed system intervention**
- **Perpetrator's access to firearms.**

**For Lori:**

- **Recent separation**
- **Past strangulation**
- **Suicidal threats and depression on the part of the perpetrator**
- **History of abuse in the relationship**
- **Assault with a weapon including holding a gun to her head**
- **Threats to kill**
- **Perpetrator's access to firearms**
- **Stalking and constant monitoring**
- **History of substance abuse on the part of the perpetrator**
- **History of failed system intervention**
- **Extreme jealousy and possessiveness**
- **Isolation.**



***Commonalities***

Both of these women were in the process of separating from their partners. In fact, they both had Temporary Protective Orders and divorces pending at the time of the attacks. Neither of them had taken these steps before, and by doing so, they were sending serious messages to their partners about their desire to end their relationships.

It is also important to note that in both of these cases, neither woman had a documented history of serious or visible injuries from prior assaults. In one instance, Sylvia did suffer a black eye while she was on maternity leave. She specifically told us she was able to hide this injury because she was on leave from work. She also said Robert was careful never to hit her again where he would leave visible evidence. Even though these women were in serious danger, their situations may have presented themselves to responding officers and the courts as less serious due to a lack of visible or serious injury. As numerous fatality cases have indicated, however, a history of serious or visible injury will not always be present in cases where women are later killed.

**In all four of the near fatality cases we have reviewed over the last three years, the victims were shot.** Lori's husband collected weapons and owned a case full of guns. Sylvia's husband was a convicted felon and should not have been able to legally have a firearm. These cases follow the disturbing trend in our overall data in which 54% of the fatalities we have reviewed have been caused by abusers with guns. Courts and law enforcement need to implement effective mechanisms for immediate gun removal to send the message that they are serious about stopping abusers from using firearms to assault their victims.

*We honor Sylvia and Lori for their courage, and we are grateful to them for sharing their stories of survival.*

# *disclosing domestic violence: where survivors go & why*

Where do survivors go for help and why? These are key questions that we must struggle with as we consider how best to help domestic violence survivors and how to intervene with perpetrators to prevent domestic violence homicides.

In all of the homicide and near-homicide cases that we reviewed this year, the victim reached out to family, friends, neighbors, or coworkers about the abuse. Sometimes they also chose to access help from professional systems designed to respond to domestic violence, such as the courts, law enforcement, or domestic violence agencies, but they appeared to do so only after they first sought help from family, friends, neighbors, or coworkers. This pattern of help-seeking is consistent with what we have found in previous years of the report as well as fatality review findings and research from other states.[3]

### *Why Do Survivors Go First to Family, Friends, Neighbors and Coworkers for Support?*

In some ways, this is not a very difficult question. Survivors go where most of us go when we have a problem or issue that is troubling us. We go to people that we trust and where we believe we are less likely to receive rejection and negative judgment. Family, friends, neighbors and coworkers are easily accessible and are likely to understand what is important to us, our beliefs, and our culture. They are also in a position to offer meaningful support that would be difficult or impossible for professional systems to provide. For example, a friend might babysit for our children and let us borrow their car to go for a job interview. Even though professional systems like domestic violence agencies and law enforcement exist in part to help survivors, survivors are likely to continue to go first to those people that are closest to them for support. This is not a bad thing, in that it puts the work of support in the hands of the community, so that professional domestic violence agencies are not alone or isolated in the work. The challenge, then, for professional service providers is to find ways to better equip family, friends, neighbors and coworkers to respond to survivors and abusers in helpful and meaningful ways that complement what professional systems can offer.

[3] For example, the Family Violence Prevention Fund report, *Preventing Family Violence: Community Engagement Makes a Difference,* states, "Studies show that abused women turn first to those closest to them – extended family, friends, neighbors – before they reach out to an organization or professional service provider. And they seek out government institutions – police, courts, and child protection agencies – last."

### *Mixed Responses from Families and Friends*

In this year's reviews, victims received different responses as they approached family, friends, neighbors and coworkers for assistance. Sometimes the response was helpful. For example, after learning about the abuse her daughter was experiencing, one mother accompanied her daughter to the local domestic violence agency for help. Another mother allowed her daughter to stay with her periodically and was helping her daughter write a letter to break her lease so that she could move away from her abuser.

Often, however, the response was not as helpful as it could have been. Frequently, family, friends, neighbors, and coworkers seemed to truly want to help the victim, but did not know what to do. Most did not appear to be aware of the range of services available at the local domestic violence agency or, if they were aware, did not refer the victim there. Also, they did not always recognize the seriousness of the danger that the victim faced. Sometimes they acted in ways that actually put the victim in more danger. For example, one sister told the victim that if she moved back in with the abuser, the sister would not speak with her again. This ultimatum limited the victim's self-determination and options as she made difficult choices to keep her family safe. While her intention was to keep her sister safe, the effect of her words was in some ways similar to the effect of the abuser's actions, in that she was attempting to control her sister's choices.

And, of course, sometimes family, friends, neighbors and coworkers were simply not supportive of a victim. One mother witnessed her son holding a gun to her daughter-in-law's head and did not intervene with her son. Later, after her son shot and almost killed the victim and then killed himself, the mother told homicide investigators that she blamed the victim's behavior for her son's violence and suicide. While victims reach out to family, friends, neighbors, and coworkers because they hope that they will be supportive, we find that their responses sometimes include victim blaming and a lack of understanding about the dynamics of domestic violence.

### *Barriers to Reaching Out to Professional Systems*

Not all victims in this year's reviewed cases reached out to professional systems like law enforcement, the courts, or a domestic violence agency for support. In two of the six cases that we reviewed this year, the victims suffered abuse but did not reach out to any formal system for help before the perpetrator killed them. This is consistent with previous years' findings, in which a significant percentage of victims did not go to professional systems for help. What barriers keep survivors from contacting law enforcement, the courts, or domestic violence agencies sooner, if they contact them at all?

- ***Victim Blaming:*** Unfortunately, just as victims are too often judged and blamed when they reach out to family and friends, victim blaming is also one of the major obstacles survivors must endure as they reach out to professional systems for help. Victim blaming from professionals may include direct questions such as, "What did you do to provoke him?" or "If it's that serious, why do you stay?" or it may be manifested as very subtle variations of those themes. Even after years of educating various systems about the dangers of victim blaming, why do these continue to be widespread responses to survivors who break their silence and reach out for help? Victim blaming serves several functions. If we can convince ourselves that the abuse is the survivor's fault - that it is a result of her own personal pathology and that she is somehow different from us (i.e., "she likes the abuse," or "they're just a couple of drunks who fight a lot") – then we can avoid recognizing our own vulnerability and the reality that abuse could happen (or is happening) to us or our loved ones. In addition, by blaming the survivor, we identify domestic violence as a personal problem rather than a societal problem. We divert attention away from our responsibility to change the societal norms and beliefs that support abuse, and we divert attention away from the ways in which our communities and professional systems have failed to keep the survivor safe and hold the perpetrator accountable. In addition, it is often safer for us to blame the survivor. Almost by definition, the abuser is more powerful than the survivor – economically, legally, physically – and is thus more threatening to us. For many of us, it is simply easier, less disturbing, and less challenging to hold survivors responsible than it is to confront abusers and hold them accountable.

- ***Oppression:*** When they reach out for help, most survivors must contend with increased danger from their abuser as well as the possibility that the person or system they go to for help will blame them for the abuse that they are experiencing. In addition to these obstacles, many survivors are members of marginalized communities that are oppressed on other levels. People of color, women, gay or lesbian survivors, survivors with disabilities, economically poor survivors, survivors who are refugees, immigrants, undocumented immigrants, or members of religious minorities like Muslims, Jews, or Hindus – each of these groups faces additional oppression in our society. This oppression may make survivors from oppressed groups reluctant to approach professional systems, as those systems may act in ways that perpetuate the oppression and reinforce it.

For example, one woman from a case that we reviewed was a refugee from Rwanda. Even though she was suffering abuse, she chose not to contact law enforcement. While it is possible that some of her reluctance to contact law enforcement may have been related to her experiences with law enforcement or the military in her home country, her reluctance raises additional questions. Despite the fact that she was a refugee and here legally, to what extent did anti-immigration rhetoric in the media and the government act as a potential barrier to deter her from seeking help? Did she fear that law enforcement intervention would be more harmful than helpful if it was compromised by racism and anti-immigration policies or sentiments? Did her multiple layers of oppression (i.e. being a refugee, a woman, and a person of color) compound to make it less likely that she would choose to access professional systems for help, and less likely to receive an adequate response if she did call?

### *What We Can Do*

For those of us who work within professional systems like law enforcement, domestic violence agencies, or courts, **this information about survivor help-seeking behavior challenges us to examine our practices.** What does it mean to us that survivors reach out first to family, friends, neighbors and coworkers? How does it affect the way we do our work, to know that some survivors are reluctant to reach out to our systems because they fear that they will receive responses including victim blaming and possibly mistreatment if they are a member of an oppressed group? **Here are some suggestions of ways we can use this information. These suggestions may not be applicable to all systems, but they can be used to stimulate creative thinking about responses within all systems:**

- ***Remove Barriers to Working with Family, Friends, Neighbors and Coworkers:*** Agencies should examine their policies and remove barriers to working with family, friends, neighbors, and coworkers. For example, domestic violence agencies should ensure that their crisis line advocates are trained and prepared to offer support to all these groups if they call.[4] Once advocates are trained and ready, domestic violence agencies should promote the crisis line to family and friends in addition to survivors. Note: It is important to remember that the "friend" or "neighbor" who calls may actually be a survivor who is in need of information, but is not ready to disclose her or his status.

[4] For more information about how domestic violence agencies can proactively work with family and friends, please see the document, "Model Protocol On Working with Family and Friends of Domestic Violence Victims," from the Washington State Coalition Against Domestic Violence. Available at www.wscadv.org under "Resources" and then "Children and Families."

- ***Expand Scope of Services:*** Agencies should proactively work to expand outreach to include family, friends, neighbors, and coworkers. For example, when responding to a domestic violence call, law enforcement should safely distribute domestic violence information to bystanders who are allies of the victim in addition to the victim. Also, at every community training, domestic violence agency staff should discuss ways in which family members, friends and coworkers can play a key role in supporting survivors. Trainings should include examples of how family and friends can safely and helpfully engage loved ones, dynamics of domestic violence, how and why to avoid victim blaming, and where to refer survivors for support (1-800-33-HAVEN). Training should also include the fact that family, friends, neighbors and coworkers can call 1-800-33-HAVEN for safety planning and support as well.

- ***Examine Our Response to Survivors:*** Agency staff should take a second look at how agency policies and interpersonal reactions may affect survivors, and ask questions such as, How are survivors perceived and treated within our organization? Do we send them subtle messages that they are inferior or that they do not know what they are doing? Do any of our policies or practices intentionally or unintentionally cut them off from the support of family and friends? For example, domestic violence agency policies that forbid shelter residents from contacting their family members in all cases, or that require shelter residents to attend all program activities with no leeway for rescheduling, may have the effect of keeping survivors from maintaining or building the relationships with family and friends that could help them stay safe in the future. We need to increase our consciousness of the ways that our institutional power and authority can be perceived by survivors as dismissive, disrespectful, or controlling. These responses serve as barriers to survivors seeking help, and they also reinforce the messages of minimization, denial and blame that batterers use.

- ***Develop Cultural Competency:*** Agencies should strive to hire staff at all organizational levels, including leadership, that reflects the diversity of communities being served. Agencies should build mutually beneficial relationships and partnerships with programs and community organizers who work with oppressed communities. Agency staff should work together to proactively examine their own biases, reflect on how these biases may affect members of oppressed populations, and take steps to correct biased behavior. Agency staff should also examine agency policies and remove any policy or practice that discriminates against any members of oppressed populations. In addition, agencies should ensure that they have materials that are culturally competent and linguistically appropriate for members of their community.

# *insight from family and friends*

In the last five years of fatality reviews, the family and friends of domestic violence homicide victims have provided us with some of the most valuable insights into the experiences of their loved ones. One way we have gathered information about the reviewed cases is from the homicide investigation interviews obtained through the Open Records Act. Additionally, in many cases the family and friends of victims have graciously given their time and energy to this process via interviews with the Project Coordinators. These interviews have added depth and breadth to the scope of the information we have for the case review and have enriched our process immeasurably. The interviews have also opened our eyes to the real impact domestic violence and homicide have on families and communities.

### *Process*

The Washington State Coalition Against Domestic Violence, which provided us with technical assistance, conducts family and friend interviews, but not all fatality review projects do. We did not take our decision to do so lightly. We approached it with a measure of certainty and a measure of trepidation. The certainty came from a belief that families have the right to know their loved one's case is being reviewed and should have the opportunity to provide information. The trepidation came from the fear that we would inflict pain on these individuals by asking them to talk about what had to be one of the most painful experiences of their lives. In an attempt to lessen any negative impact, we followed a carefully thought-out and specific model for contacting them. If a member of the Fatality Review Team, such as a Victim Witness Advocate, has a relationship with the family, then that person makes the first call to the family. They give the family some information about the process and ask for their permission to be contacted by the Fatality Review Project Coordinator. In the absence of this relationship, the Project Coordinator sends a letter to the family. This letter explains the Fatality Review process, the kind of information being sought, and gives them options for relaying whatever information they wish to share, in writing, via a phone interview, or via an in-person interview. If a friend or family member agrees to be interviewed, we work to ensure that the process allows them to share as much or as little information as they are comfortable with, in whatever way they choose.

### *Personalizing the Victim*

One way in which the interviews with family and friends have enriched our review process is by personalizing the victim. Interviews with family and friends often begin with an open-ended question inviting them to share what they would want us to know about their loved one. Their answers often involve descriptions about what kind of person the victim was, such as "very caring," "family oriented," and "someone who always had a smile." In one interview, a woman described her deceased sister as a "good person who would do anything for anybody." In another interview a brother described his deceased sister as the "center" of their close knit family. A best friend described a victim as someone who "believed in trying to make a family work."

### *Understanding the Victim's Choices*

Family and friends also have a wealth of information about their loved ones' contact with various systems. This is particularly enlightening because their observations often involve the victim's perception of what her options were. One young woman had told her mother that she wanted to leave her live-in-boyfriend, but she was afraid to break her lease. Her mother was helping her write a letter to her landlord in the hope that she could terminate her lease early without consequence.

Family and friends have also provided valuable insights into their loved ones' attempts to end their relationships with abusive partners. One family believed the perpetrator killed their loved one because she told him he was going to have to move out the next day. They described her multiple attempts to engage the criminal justice system to help her get him out of her house and said "she wanted to be free from him." Another family detailed their loved one's attempt to leave the batterer ten years before the homicide. She took the children, moved out of state and leased an apartment with her sister. While she was there, her husband called her repeatedly and threatened to kill himself if she did not return to him. She eventually went back to him. A rabbi detailed a woman's efforts to learn English and secretly save money so she could leave her abusive husband. Just days before another young woman's death, she told her mother that she was afraid of her boyfriend and "was ready to get her life together."

### *Impact on Family Members*

Family and friends were also able to articulate for us how the loss of their loved ones impacted their families. Most of our conversations with family and friends happen at least two years after their loss, yet the lasting effects of grief and trauma ripple through our conversations. In one interview with a brother, he described his battle with the insomnia that still plagues him a year and a half after his sister's death. In this same family, the victim's ten-year-old son discovered her deceased body and told his uncle "I look in the mirror and see my mama lying in the bed." His twin sister was with him when he found their mother, and neither child received counseling.

One victim's friend has maintained a relationship with the victim's daughter, who is now in her early twenties. It is not unusual for the friend to receive a call from the daughter in the middle of the night crying out in grief and anguish over missing her mother so terribly. This friend

also worked with the victim, and three years later she sometimes "forgets" what has happened and looks for her friend's car when she pulls into her parking lot at work.

We found that for many of these families, the impact of the homicide also involves economic hardship. In one case, the victim's income helped support a brother who was disabled. After her death, he said, "We are going to be struggling." In many families, parents or siblings of the deceased take on child-rearing responsibilities for the victim's children. These situations present unique parenting challenges and additional expenses.

Most family members and friends that we have interviewed in this Project have expressed a sense of catharsis at having been able to talk about their loved one in a way that could potentially change an outcome for another. Several conveyed that they would never wish this kind of pain on another person and would be willing to help if it would help another. One person said "I appreciated you being interested."

### *Feedback to Criminal Justice System*

Many families expressed strong opinions regarding the criminal justice system's response before and after the homicide. Many felt as though the system failed their loved one when they sought help prior to the homicide. Examples of this include law enforcement officers not making arrests, prosecutors plea-bargaining or using diversion, and judges ordering lenient sentences. Many families expressed anguish and disbelief at the sentences the perpetrators received after the homicide, believing them to be too lenient and not fitting the crime. One mother declined to speak with us because after her 29-year-old daughter was shot twice in the head by her boyfriend, the court sentenced him to ten years, with only four to serve. He was released from prison in May 2007, four years and one month after the homicide. The impact of the trial is also hard for friends and family. It is not easy for them to sit in court and hear their loved one disparaged by the perpetrator's attorney. While the trial was difficult, many said that victim advocates were a source of comfort during the trial.

### *Moving Forward*

The insights that family and friends have provided through this Project are crucial in our efforts to end domestic violence. First, we have learned that prior to the homicide family and friends knew more than anyone else about the dynamics and events that indicated danger and led up to the homicide. These individuals are potentially the most motivated to help, but are often unaware of how to help and unsupported in their potential role of preventing serious injury and death. Second, we have learned that follow-up services for family, friends and surviving children of domestic violence homicide are not adequate. Moreover, the grief and struggles they have detailed for us should renew our sense of urgency and commitment to creating the true social change that is necessary to end domestic violence and create safer communities.

These insights have important implications for how we do our work. Awareness campaigns through workplaces, in faith communities, community organizations and via the media are needed to educate family and friends about their potentially powerful role in saving lives. These education efforts must encourage family and friends to reach out to the local domestic violence agency for help in supporting a loved one. In turn, domestic violence agencies must adopt best practices for working with the family and friends of a loved one. For more information about how to support a loved one who is either being abused, or being abusive, please see page 36 of this report.

# *promising practices*

As the work of Domestic Violence Fatality Review continues here in Georgia and nationwide, several solutions for addressing domestic violence and preventing homicide are emerging as innovative and promising practices. This section highlights three such approaches that we hope will be considered by communities in Georgia and beyond as they seek ways to make their communities safer.

### *Engaging the Faith Community: An Example from the Conasauga Judicial Circuit*

An important finding that has emerged from Georgia's review of domestic violence fatality cases is the significance of faith communities within the lives of victims, abusers and/or their families. The cases reviewed in each year of this Project have indicated that victims are more likely to be connected to a place of worship than to a domestic violence agency. In some instances, victims sought guidance and counseling from faith leaders prior to their homicide or near-fatal attack. In other cases, clergy or fellow congregants were aware of the violence due to concerns voiced by extended families. Sometimes victims were connected with their faith communities but were unwilling or unable to disclose the abuse there. There were also multiple cases in which the abuser held a prominent position in his congregation. If prepared, leaders or members of these religious organizations might have played an important role in holding those abusers accountable and intervening in their violence. And yet, despite the importance of the faith community for so many victims and perpetrators, many Fatality Review Teams and Domestic Violence Task Forces have found it difficult to involve faith groups in the work of stopping abuse. There are a variety of reasons why this collaboration has often proven challenging. Many clergy lack awareness of the scope of the problem within their congregation, or what their role might be in addressing it. Additionally, intervening in domestic violence situations presents a

challenge to the commonly held belief that faith leaders must remain neutral in family conflicts.

What would it take to build bridges between the faith and domestic violence communities so that faith leaders would reach out to domestic violence advocates for guidance when they discover abuse? How could we train and motivate clergy so that domestic violence survivors in their congregations would feel safe enough to disclose the abuse? What would encourage spiritual leaders to value the idea of sitting down with a group of congregants and advocates to plan the safest way to hold an abuser accountable? How do we begin to build the connections that would make these things possible?

One community in Northwest Georgia, the Conasauga Judicial Circuit, including Whitfield and Murray counties, has begun to answer these questions. The Conasauga Judicial Circuit's recent work in this arena provides a model for others to follow as well as lessons to be learned for future efforts. Our hope is that their example will inspire other Fatality Review Teams and Domestic Violence Task Forces to undertake similar efforts to engage faith communities in their own areas.

On October 13, 2008, the Conasauga Judicial Circuit Domestic Violence Task Force, the Northwest Georgia Family Crisis Center, the RESOLV Project, and the Dalton State College of Social Work sponsored the Second Annual Domestic Violence Conference in Dalton. This sponsorship collaboration between the Task Force, the DHR-certified domestic violence agency, the local Family Violence Intervention Program (FVIP), and the local college is noteworthy in itself as an example of key agencies working together to lead a domestic violence initiative. Funding for the conference was provided by the Community Foundation of Northwest Georgia and the RESOLV Project (a certified Family Violence Intervention Program). 140 people attended.

The conference keynote speaker was the Reverend Dr. Marie Fortune of the FaithTrust Institute (www.faithtrustinstitute.org). Dr. Fortune also moderated a panel of local and regional faith leaders who responded to questions about domestic violence. The conference's leadership team chose Dr. Fortune for several reasons. Many of the members were aware of the quality of Dr. Fortune's work and regularly use newsletters and resource materials from the FaithTrust Institute in their work. In addition, the Task Force recognized their longstanding difficulty in recruiting faith leaders to participate in Task Force meetings. Dr. Fortune's presence was seen as a way to stimulate involvement. Also, domestic violence advocates have observed that faith communities, intending to help, have sometimes been a roadblock instead of a support for many abused women, and the group wanted to address this problem. Finally, Georgia's 2007 Domestic Violence Fatality Review Report's "Spotlight on Faith" section stimulated a sense of immediacy to address faith issues within the community.

To recruit faith leaders, the conference leadership team employed multiple strategies. First, the team sent two letters to local congregations advertising the training. Members of the leadership team also reached out to their own faith communities to personally invite them to attend. Last, they created a panel of local faith leaders to speak to their peers. Despite these multiple efforts to recruit clergy, general attendance by faith leaders was still relatively low. To boost their attendance in future workshops, the leadership team discussed the need to identify key clergy and recruit them to invite their peers to the training.

The Conasauga Judicial Circuit's conference is an important example of an effort to build connections between the faith and domestic violence communities, and we hope that other communities will undertake similar efforts. Based on their experience, the conference leadership team has lessons to share with other communities that want to plan faith-based trainings. First, the leadership team liked the clergy panel concept and thought it was a useful way to involve local clergy and foster dialogue. However, some of the clergy on the panel lacked awareness about the dynamics of domestic violence. To remedy this, the conference leadership team recommends having a pre-conference training with panelists. In addition, they suggest designating a publicity chair who can spearhead advance publicity of the event and issue an informative press release as a follow-up mechanism, working closely with the local media to accurately portray key concepts from the training.

The Conasauga Judicial Circuit conference leadership team also recognizes the need to build on the success of the conference and to continue to do outreach to the faith community. They suggested this might be done by:

- creating a domestic violence brochure to be distributed to a more extensive mailing list;
- recruiting the leaders of four prominent congregations to write a joint letter and mail it with the brochure to all the other local congregations; and,
- designing a follow-up workshop on faith for their 2009 Annual Conference.

Additionally, the conference leadership team has recommended that the Georgia Commission on Family Violence and the Georgia Coalition Against Domestic Violence send a joint letter to all seminaries in Georgia requesting that they incorporate domestic violence education into their curriculum and assure that their students receive information about other domestic violence training resources. For more information about engaging the faith community in our work, please see pages 24-25 of the Georgia Domestic Violence Fatality Review Project 2007 Annual Report.

### *Building and Sustaining Momentum for Fatality Review: An Example from the Western Judicial Circuit*

Georgia's statewide Domestic Violence Fatality Review Project is not the only effort in the state to review domestic violence homicides. One community, the Western Judicial Circuit, initiated its own Fatality Review process prior to the formation of the statewide Project, in response to a local tragedy. This project has been operating successfully at the local level for seven years. We highlight their work here as another potential model for other communities to consider replicating if they are interested in creating a Fatality Review process in their community.

#### *History*

In 2001, an Athens-Clarke county government employee was killed in her front yard by her ex-boyfriend before he turned the gun on himself. Later that same year, the Domestic Violence Task Force (DVTF) of Athens-Clarke and Oconee Counties, spurred on by trends in domestic violence crime as well as the personal loss felt by many of the members at this recent tragedy, created the Domestic Violence Fatality Review Subcommittee (DVFRS) to provide a process for domestic violence fatality reviews in the Western Judicial Circuit of Georgia.

From March 2002 through June 2003, representatives from several agencies met to conduct the initial conversations and planning. Agencies represented included the local domestic violence agency, Project Safe; the University of Georgia's Family Violence Law Clinic for Temporary Protective Orders; the Solicitor General; the Solicitor General's Office of Victim Assistance; the District Attorney's Office; Georgia Legal Aid; The Cottage Sexual Assault Center and Children's Advocacy Center; the Clarke County Department of Family and Children Services; the Clarke County School System; and Family Counseling Services, a United Way-funded counseling agency that also offers a Family Violence Intervention Program. Working together, this group used the fatality review model from the Washington State Coalition Against Domestic Violence to develop the framework and protocols needed to conduct fatality reviews in their community.

Once the DVFRS agreed on a clear framework for conducting fatality reviews, they submitted their plan to the full DVTF. When the DVTF approved the plan, the DVFRS evolved into what is now called the Fatality Review Panel (FRP). The chairs of the DVTF identified agencies that were not represented on the FRP and contacted them to request a member representative. The DVTF chairs also appointed an interim chairperson for the FRP by majority vote.

It became clear during the 1½-year planning stage that no one agency had the staff or time to complete the tremendous amount of work it takes to incorporate agency information into a summary for each review. Therefore, a Violence Against Women Act grant application was submitted in 2003 and led to the hiring of a part-time Fatality Review Coordinator. The Coordinator's primary functions are to gather necessary records, synthesize the information and support the work of panel members to implement recommendations. The Coordinator's responsibilities also include contacting, encouraging, and motivating other representatives to assist in case searches, attend FRP meetings, and provide other support. The coordinator's role appears to be key in the sustainability of the FRP.

#### *Organizing Principles*

The individuals involved in the initial planning knew that to be truly successful they would need multi-agency buy-in. An earlier attempt to review non-fatal, high-risk domestic violence cases had dissolved due to some concerns within the group regarding the confidentiality issues of looking at open cases. This experience taught them how important it is to work towards a group consensus when trying to organize individuals around tough issues. When it came time to pursue grant funding through the Criminal Justice Coordinating Council for the project, Project Safe, as the applicant, made a special effort to frame the application and the project as belonging to the entire DVTF rather than being a program of their own. Again, this was a way to foster group ownership of this initiative.

Another dynamic that exists in the Western Judicial Circuit that also contributes to the success of the FRP is their Family Protection Center. This Center provides a single facility for collaborative services between multiple agencies that work with child abuse, sexual assault, and domestic violence cases, including the Georgia Division of Family and Children Services (DFCS), the Sexual Assault Nurse Examiner (SANE), Project Safe, the Athens-Clarke County Police Department, The Cottage Sexual Assault Center and Children's Advocacy Center, and the District Attorney. This co-location of services is beneficial to survivors, and it also serves as a conduit for multi-agency collaboration. Agencies are able to provide survivors with multiple services in one visit, and these same agencies develop relationships with each other that might not otherwise happen if they were not in shared space. These relationships strengthen the trust among members that is necessary to have a successful fatality review team.

#### *What They Learned*

After approximately two years of conducting fatality reviews, the Panel made several significant findings. Their findings were similar to those of other communities conducting fatality reviews:

- Most domestic violence victims had no contact with community domestic violence advocates prior to their homicide.

- Friends, family, and/or co-workers were aware of the abuse but felt inadequate or lacked knowledge about providing support.
- 25% of the cases involved homicide-suicides.
- Weapons removal for domestic violence offenders should be a top priority. In the first twelve cases reviewed, eight perpetrators used guns to kill the victim, and another used a knife to kill his victim and a gun to kill himself.
- Abusers rarely faced consequences for crimes they committed prior to killing or attempting to kill their partners, such as when their cases were dismissed or the case disposition was protracted.

***Changes They Have Made***

Since the inception of the Fatality Review Panel, the Domestic Violence Task Force has made the following changes to their community's response to domestic violence. It is important to note that not all of the changes listed below are direct results from fatality review findings.

- The Fatality Review Coordinator began reviewing police reports in April 2006. The Coordinator screens the reports for those involving domestic violence and passes them on to the victim liaison, who calls victims to offer services and safety planning. In January 2009, this outreach will begin in a second county.
- A victim liaison now attends domestic violence bond hearings to assist victims and offer resources.
- In an effort to increase offender accountability, domestic violence case dispositions are tracked so that the offender's completion of a Family Violence Intervention Program is monitored by a committee that includes the following members: the Fatality Review Coordinator, the Solicitor General, Victim Assistance Program director, Family Violence Invention Program provider, Family Counseling Services drug counselor, drug court supervisor, and private probation (now to be county probation). This group meets periodically to review compliance of all offenders who were ordered through a criminal court to attend FVIP.
  - When it is discovered that a probationer has failed to comply with the court order, the Solicitor General will ask Probation to request a warrant for non-compliance.
  - For civil orders (TPOs) where the offender is not already involved in a criminal disposition, the Judge completes a Family Violence Intervention Compliance Form. The Respondent is required to return a notice of enrollment to the Director of the Victim Assistance Program at the District Attorney's Office who volunteered to handle this responsibility. The Director of the Victim Assistance Program is also responsible for filing contempt orders for failure to comply if the Respondent in a TPO case was ordered to complete an FVIP and has not.
  - The county government decided to end private probation for misdemeanor cases and create a county probation department. The new county probation officers will be P.O.S.T.-certified and authorized to go to a probationer's residence to serve probation warrants when necessary.
  - In August 2008, the Solicitor General's office started designating Domestic Violence Fast Track Cases in an effort to expedite the handling of certain domestic violence cases. Cases are fast-tracked when they have the presence of several lethality indicators and are presented to the court two weeks from the time of arrest. The decision to fast track is made by Magistrate Court judges. This process was implemented with the belief that moving quickly towards an earlier disposition of the domestic violence case demonstrates to the victim that this incident and victim safety are important to the court. It also demonstrates to the offender that the court is serious about the offender's punishment and compliance. Earlier case disposition also shortens the time the offender has to persuade or entice a victim back into the relationship. It may also decrease the amount of time the victim is anxious and worried about immediate safety and offender retaliation. Between police report contacts, bond hearing contacts and Domestic Violence Fast Track contacts, the Victim Liaison is offering support and services to many more victims, and offering them earlier in the criminal justice process.
  - While the Panel continues to conduct fatality reviews, there has been a shift towards a process they refer to as "staffing" cases. Cases that meet the criteria for staffing are felonies and serious misdemeanors that did not involve a fatality and are usually brought to the attention of the FRP by the Solicitor General, the District Attorney, victim advocates or domestic violence detectives. Cases that are "staffed" are pending cases where there is concern about victim safety, lack of offender accountability, and/or about a potential for reoccurrence. The process of "staffing" cases involves the same methodology of gathering information and examining systemic response as cases involving fatalities. Often, the FRP "staffs" cases when there are no fatal or near-fatal cases eligible for review at that time.

The FRP continues to meet every month for about an hour. They review a case until all of their questions and concerns are answered before they move on to another

one. Over time, the members of the FRP have built trust and good communication within the group and are able to respect each agency's position while not always agreeing. They see their work as ongoing because they know it takes time to create change. This respectful collaboration, as well as the energy contributed by each member, is an important part of what helps this group sustain its momentum.

### *Lethality Assessment Program: An Example from Maryland*

In the cases reviewed by the Georgia Domestic Violence Fatality Review Project between 2004 and 2008, only 18% of homicide victims had contact with a domestic violence agency or safehouse in the five years leading up to the homicide. Clearly, it is imperative to find ways to connect more people who are in danger of being killed with the safety planning, shelter, and support services that domestic violence agencies can provide.

While relatively few victims had contact with domestic violence agencies before they were killed, many more had contact with law enforcement. Fact: homicide victims had far more contact with law enforcement than they did with any other service provider or agency. In the five years leading up to the homicide, 77% of victims in reviewed cases had contact with law enforcement. This causes us to ask: Are there best-practice models of collaboration between law enforcement and domestic violence agencies that effectively connect survivors at risk of being killed with safety planning, shelter and support services?

One promising practice in this area comes from Maryland. The Maryland Network Against Domestic Violence has developed a program called the Lethality Assessment Program for First Responders. The Lethality Assessment Program provides law enforcement officers with an eleven-question screening instrument based on research by Dr. Jacquelyn Campbell of Johns Hopkins University. The screening instrument takes about two minutes to perform. If the screen reveals that the person is at an increased risk for homicide, the officer privately tells the survivor that she/he is in danger and that in similar situations, people have been killed. The officer then immediately calls an advocate at the domestic violence hotline and offers the phone to the survivor. If the survivor chooses not to talk with the hotline worker, the officer reviews the lethality factors with the advocate and seeks advice. The officer also provides the survivor with referral information to the hotline and encourages her/him to call. If the survivor does choose to speak with the hotline worker, hotline responders have been trained to do brief safety planning with the survivor and to encourage her/him to come in for services and more extensive safety planning.

While simple in concept, the Lethality Assessment Program is having a profound impact in Maryland. Eighty-seven Maryland law enforcement agencies are participating in the program. To date, law enforcement officers have conducted over 9,800 lethality screens. Of those screens, 5,600 people were determined to be in high danger. Of those 5,600 high danger cases, 3,100 people chose to get on the telephone with a domestic violence hotline worker and 854 chose to go in to a domestic violence agency for services. The Maryland Network Against Domestic Violence estimates that 2 people a day go into domestic violence agencies for services because of the Lethality Assessment Program.

The Lethality Assessment Program was recognized by Harvard University as a Top 50 Program for 2008. For more information about the Lethality Assessment Program, go to www.mnadv.org/lethality.html or call the Maryland Network Against Domestic Violence at 1-301-352-4574.

## *broadening the scope*

The Fatality Review Project is dedicated to learning from all domestic violence-related deaths. Until this year, domestic violence fatalities reviewed in this project were homicides in which the victim and the perpetrator were current or former intimate partners. Homicide cases involving other victims such as a friend, current partner, child or family member of the domestic violence victim were also considered domestic violence-related. Additionally, four attempted homicide cases involving domestic violence victims who survived an attack on their life by their current or former intimate partner have been reviewed. In all of these cases, the victim died or nearly died as a direct result of a violent attack committed against them by the domestic violence perpetrator.

These cases have yielded invaluable lessons, but in order to fully understand the scope of the problem of domestic violence-related death, we must recognize that women die as a result of domestic violence in a variety of ways, not just from a lethal act of physical violence. In some cases, for example, a woman who has been subjected to years of abuse may feel that the only way to escape the abuse is to take her own life. These deaths by suicide are rarely counted as domestic violence deaths, but when the violence clearly seems to be a primary cause of the suicide, we have much to learn from them as domestic violence-related fatalities. Likewise, women whose abusive partners knowingly infect them with HIV are rarely counted as domestic violence fatalities. Yet when transmission of the disease is used as a tool of abuse – one that eventually proves fatal – these deaths, too, warrant further study as domestic violence fatalities. These are just a few examples of the kinds of "hidden" fatalities that are actually domestic violence deaths. In this section, we hope to challenge Fatality Review Teams to take into account factors like

these, and consider expanding the kinds of cases they select for review as domestic violence deaths.

### *Suicide*

Suicides of battered women are rarely reviewed by Fatality Review Teams, but research suggests there is a strong need to take a closer look at these cases to see what lessons can be learned. Domestic violence victims often feel trapped, powerless and isolated. They may become clinically depressed and may not receive treatment for their depression. This can lead to a victim believing that suicide is the only way out of an abusive relationship.[5] In fact, a significant number of the 6000 women who commit suicide in the United States each year likely do so because of being abused by an intimate male partner.[6] In one study, Evan Stark and Ann Flitcraft found that "among the medical histories of the 176 women who attempted suicide, 29.5 percent were battered" and "22.2 percent had at least one documented incident of domestic abuse in their records."[7]

In 2008, in an effort to expand the Project's scope of reviewed cases, one Georgia community reviewed a case involving a woman who committed suicide after enduring years of well-documented abuse at the hands of her husband. This woman suffered sexual, emotional and physical abuse during her twelve year marriage. As a result of the abuse, she had contact with multiple systems, including the Department of Family and Children Services, law enforcement, the civil courts for Temporary Protective Orders and divorce proceedings, the criminal courts, and a Court Appointed Special Advocate. Her husband was arrested multiple times for his violence against her and others and for drug- and driving-related offenses. Six months before her death, she received threatening letters from him while he was in jail. These letters expressed his intent to continue to make her life miserable, and she filed a Temporary Protective Order that was still in place when she committed suicide. Her family believes she committed suicide because the accountability measures that were put in place by the criminal and civil legal systems did not seem to deter her husband's violence against her. They believe she felt that ending her own life was the only way to end his violence. The Fatality Review Team that reviewed this domestic violence-related suicide learned valuable lessons from examining this case. We encourage other Teams to consider reviewing similar cases in their communities.

### *HIV/AIDS*

There is evidence to suggest that the connection between being a battered woman and increased risk for HIV is one that warrants further exploration. A study conducted by Neil Websdale and Byron Johnson found that battered women may be more vulnerable to HIV infection than other women for a variety of reasons, including forced sex and the inability to insist on condom use in abusive relationships.[8] As a result, Websdale notes that "some deaths of women currently attributed to HIV or its complications might be traced to a woman's status as battered."[9]

There are many ways in which HIV/AIDS affects victims of domestic violence and presents additional barriers to safety. Primarily, victims of domestic violence who have a partner who is HIV positive (HIV+) or has AIDS are threatened with transmission of the virus through sexual violence and through their inability to safely negotiate condom use with a violent partner.[10] In addition, abusers may prevent their partners from receiving medical care which may, in turn, negatively impact their health by compromising their immune system and increasing their risk for contracting HIV. Furthermore, abusers may use their own HIV+ status to control or manipulate their partners. For example, HIV+ abusers may fake illness in order to convince victims not to leave or to woo them back if they have left.

Once a victim has contracted the virus, there are many ways abusers may use their partner's HIV+ status to continue or excuse their violence. Abusers may sexually humiliate or degrade their partners for being HIV+, or may tell them that they are "dirty" or undesirable. In addition, abusers may isolate their victims on the basis that they pose a threat of infection to others, or they may threaten or refuse to assist victims when they are ill. Abusers may also threaten to reveal the victim's HIV+ status to their children, family, friends and the victim's employer, and may threaten to use the victim's HIV+ status as grounds for obtaining custody of the children. All of these tactics impede the victim's ability to safely leave an abusive relationship and to receive adequate care for her illness.

To date, no Fatality Review Team in Georgia has reviewed a domestic violence-related HIV /AIDS death. However, victims who are HIV+ and/or whose abusers are HIV+ face additional barriers to safety that need to be explored and further understood. We encourage Fatality Review Teams to consider including HIV/AIDS-related domestic violence deaths among the cases that they review.

***Note:*** Domestic violence-related suicide and HIV/AIDS deaths present unique challenges for Fatality Review Teams. For example, it is unlikely that the abuser was prosecuted when the cause of death was ruled to be HIV/AIDS or suicide. Therefore, the abuser may still be living in the community where the review takes place. If your Fatality Review Team wants to review a suicide or HIV/AIDS death, please contact one of the Project Coordinators to strategize about how to proceed.

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[5] Suicide.org, http://www.suicide.org/domestic-violence-and-suicide.html
[6] Neil Websdale, "Reviewing Domestic Violence Deaths," *National Institute of Justice Journal* 250 (2003): 27-30.
[7] Stark and Flitcraft, *Women at Risk: Domestic Violence and Women's Health,* London: Sage Publications, 1996: pg. 107
[8] Websdale, Neil, and Byron Johnson, "Battered Women's Vulnerability to HIV Infection," *Justice Professional* 10(4) (1997): 183-198.
[9] Neil Websdale, "Reviewing Domestic Violence Deaths," *National Institute of Justice Journal* 250 (2003): 27-30.
[10] World Health Organization, The Global Coalition on Women and AIDS, *Intimate Partner Violence and HIV/AIDS,* Information Bulletin Series 1.

# *new findings and recommendations*

The recommendations listed here came directly from cases reviewed this year and have not been listed in previous reports. For a comprehensive list of all previous Findings and Recommendations of the Georgia Domestic Violence Fatality Review Project, please see pages 26-39 in our 2007 Annual Report. All previous years' reports can be accessed on the Internet via **www.gcadv.org**, **www.gcfv.org** or **www.fatalityreview.com**.

## COURTS

### *Finding*

Allegations of domestic violence often emerge in civil proceedings, including divorces, custody cases, and Temporary Protective Orders. These proceedings are potentially critical points of intervention for victims, yet representatives of the civil legal system do not always refer victims to helping resources.

### *Recommendation*

Domestic violence agencies should work with clerks and other courthouse personnel to ensure that information about their services is prominently displayed in the courthouse (in clerks' offices, restrooms, etc.).

All professionals working in the civil legal system, including judges, attorneys, court clerks, mediators, guardians ad litem (GALs), and court appointed special advocates (CASAs), should receive initial training and continuing education on domestic violence.

The State Bar Association should train all civil attorneys to refer victims of domestic violence to their local domestic violence agency for safety planning and lethality assessment.

## PROBATION AND PAROLE

### *Finding*

When a perpetrator is on probation or parole and commits a new offense, frequently their probation or parole officer is not made aware of that new offense.

### *Recommendation*

Probation and parole officers should take proactive steps to learn about violations. Most domestic violence offenders are supervised by county or private probation providers. Most of these probation entities have automated case management systems. These probation entities should contact their local Sheriff's Department and explore the possibility of having their automated case management system cross-reference the local Book-In/Inmate rosters on a daily basis. This can be accomplished by building interfaces with Jail Management automated systems where available. These interfaces could not only identify domestic violence offenders that commit subsequent crimes locally, but they could also identify other offenders being supervised for non-domestic violence offenses who commit subsequent crimes. Some offenders on supervision for general misdemeanor charges may be committing subsequent crimes involving domestic violence. Victim safety may be enhanced by probation bringing the new charges to the attention of the court promptly, which may result in swifter action by the court in addressing probation violations. Victims could be reassured that probation and the courts are diligently monitoring the offender to minimize risk and address violations effectively.

If interfaces with local jail management systems cannot be established, the supervising probation/parole authority should request a copy of the local Book-In/Inmate roster and manually cross-reference active cases with this roster. It is also advisable to periodically (preferably quarterly) run Criminal History (GCIC/NCIC) records for these offenders. (Note: Private probation entities, under contract with a court to perform the court's criminal justice administration functions, have the authority to conduct Purpose Code C criminal history record checks on probationers at any time as part of the supervision of the probationer.) These records are of even more value in the more urban areas of our state, where offenders frequently cross county lines or live and work in different counties. This information is more comprehensive and normally lists all offenses resulting in an arrest, regardless of jurisdiction. These records can also provide insight into the offender's criminal behavior patterns (based on types of offenses committed, such as assault offenses, drug-related offenses, etc.) or even assist in identifying the offender as a High Risk Offender (which can impact the level of supervision implemented in the case).

## LAW ENFORCEMENT

### *Finding*

In some instances, police officers are charging domestic violence crimes as ordinance violations, rather than as domestic violence misdemeanors under the Family Violence Act. This is a harmful practice for many reasons. First, if the case is presented to the court as a disorderly conduct case, the victim most likely will not be connected to a victim advocate. Second, the citations will not appear on the offender's criminal history. Third, if a future offense occurs, the lack of previous domestic violence convictions can prevent the graduated sanctions of the Family Violence Act from being utilized. Even though city ordinance violations come through municipal court and may be bound over to State court when the Judge hears them, this delays the time for an advocate to get the case, therefore delaying victim contact and decreasing victim safety.

### *Recommendation*

Law enforcement should make it a priority to charge domestic violence offenses under the Family Violence Act,

according to the evidence, and not as ordinance violations. Local Family Violence Task Forces should form a working group to address any systemic issues that may encourage law enforcement officers to give ordinance violations rather than charging misdemeanors.

## MEDICAL

***Finding***

Domestic violence victims who do not access the criminal justice system or the shelter system may still seek emergency care in Emergency Departments. This is a potential point of critical intervention for victims.

***Recommendation***

The Georgia Medical Society, the Medical Association of Georgia, the Georgia College of Emergency Physicians, and the Emergency Nurses Association should provide ongoing education and training to their members on domestic violence.

Social work departments in hospitals should designate or hire a domestic violence advocate on their staff.

## DOMESTIC VIOLENCE AGENCIES

***Finding***

Many victims of domestic violence face barriers to reproductive freedom that can impact their options for safety. These barriers may include issues regarding forced sex and other kinds of sexual assault as part of the violence they are experiencing, forced abortion, limited access to contraception and abortion, and limited control over their own reproductive and sexual health and fertility. When a batterer impedes a woman's efforts to control the number or spacing of her pregnancies, for example, it can have severe consequences not only for her physical and emotional health, but also for her economic stability and her options for leaving the abusive relationship.

***Recommendation***

GCADV should incorporate a training component for advocates on how to talk with survivors about whether and how their reproductive and sexual health has been affected by the violence, and how their options for safety may have been constrained by limits on their reproductive and sexual health.

Domestic violence agencies, once their advocates are trained, should incorporate those issues into their protocols for serving victims.

## APARTMENTS

***Finding***

Housing and economic issues are closely linked to the safety of battered women. Many landlords and apartment complexes do not have policies that allow victims of domestic violence to terminate their leases for safety reasons. Landlords and apartment managers often are not prepared to offer appropriate referrals to tenants who are experiencing domestic violence. In some cases, landlords see domestic violence victims as problem tenants and even evict them because of the noise and property damage inflicted by the abuser.

***Recommendation***

The Georgia Apartment Association should partner with a domestic violence agency to provide training and information about domestic violence to its member associations.

The Georgia Apartment Association should also encourage its members to evaluate their leasing policies to incorporate provisions to allow domestic violence victims to break their leases without penalty when safety is a factor, and to ensure that they do not place victims in more danger by evicting them for their partners' abusive behavior.

## ECONOMICS

***Finding***

A domestic violence abuser's dangerousness may increase during times of economic stress and unemployment.

***Recommendation***

The Georgia Department of Labor Career Centers should train employees to screen applicants for domestic violence and suicidal ideation and to make appropriate referrals.

## ABUSER ACCOUNTABILITY

***Finding***

Often family, friends, coworkers and neighbors are aware of an abuser's behavior. These same people often do not talk with the abuser about his behavior or encourage the abuser to take responsibility and change.

***Recommendation***

When the Family Violence Task Forces and other members of the community are educating the public about domestic violence, they should include strategies for safely intervening with an abuser.

Please refer to the "What You Can Do if You Know Someone Who is Being Abused or Who is Abusing" section of this report on page 36 for suggested strategies.

# what you can do

## if you know someone who is being abused...

Statistics show that ***one in every four women will experience domestic violence in her lifetime.*** As a community, we have a responsibility to respond to this problem and break the silence that keeps victims in suffering. Below are some suggestions to help you address the issue of domestic violence.

If you know someone who is being abused, here are some ***basic messages you can convey*** to help increase safety:

- I care about you and I am worried for your safety
- I understand that it is not easy to leave
- I will be here for you, even if I don't understand all of your choices
- There is a free, 24-hour hotline in Georgia where you can talk to an advocate if you ever want to, anonymously if needed: ***1-800-33-HAVEN(4-2836) (Voice/TTY)***
- Leaving an abusive relationship can be extremely dangerous. Anyone planning to leave an abusive relationship may want to consider speaking with a domestic violence advocate to create a safety plan
- Talking to an advocate and making a safety plan does not mean you have to go to a shelter or leave your partner today

***Remember this:***
*People experiencing abuse* ***rely on those closest to them*** *for support. This often includes family, friends, coworkers and members of the faith community. It is important for these people not to judge or blame the victim. This only leads to further isolation of the person being abused and will not help her get safe.*

***Remember this:***
***Safely confronting*** *someone about his violence shows that you care about him as well as about the person he is abusing. This kind of conversation might be the best chance for stopping the abuse.*

## ...or who is abusing

There are some important messages you can convey if you talk to someone who is being abusive. Think of these messages as offering the person an opportunity to take responsibility and change:

- Your behavior is going to drive the people you love away from you
- Your behavior could land you in jail
- You can change your behavior
- Your behavior may be causing your children to fear and resent you
- Your violence won't stop because you promise it will; your violence will stop when you reach out to an expert for help. You can contact the Georgia Commission on Family Violence for a list of certified Family Violence Intervention Programs via phone: 404-657-3412 or via their website: **www.gcfv.org**
- You may feel threatened or challenged by another person, but no one can make you do something you choose not to do. You are the only one who controls what you do

*www.gcfv.org* / call 404-657-3412
*www.gcadv.org* / call 404-209-0280

tear out this page and post it in plain sight

05/27/99 **Regina Manning**, 27, shot in the chest by her husband

12/05/03 **Maricruz Martinez**, 31, 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

03/05/04 **Darlene Merritt**, 38, shot by her husband who then killed himself

03/21/04 **April McMillan**, 26, shot to death in her home by a former girlfriend who was stalking her

12/01/04 **Agnes Mitchell**, 41, stabbed in the chest by her husband

06/30/02 **Rubia Neves**, 37, stabbed multiple times by her husband in the presence of her youngest child

02/04/03 **Daong Ngo**, 34, died from a head injury sustained when the father of her child slammed her head into the floor repeatedly

05/17/03 **Damita Oglesby**, 30, was pregnant when her child's father stabbed her in the head and neck with a screwdriver; she survived long enough in a coma to give birth to a son before she died

01/15/01 **Barbara Owens**, 41, stabbed to death by her husband in the presence of her infant granddaughter

03/09/01 **Audrey McCormick Pike**, 36, stabbed in the chest by her daughter's boyfriend, who was hired by her husband to kill her

09/01/02 **Helen Jones Richardson**, 41, beaten and suffocated by her boyfriend

01/14/01 **Helen Rivers**, 40, shot in the chest by her boyfriend

12/27/03 **Cheryl Grear Robertson**, 38, shot to death by her boyfriend who then killed himself

04/04/03 **Latashia Robinson**, 29, shot in the face and head by her boyfriend who then attempted suicide

08/29/04 **Cristina Santana**, 35, shot in the neck by her husband who then killed himself; their teenaged daughter was also wounded during the attack

12/15/01 **Anthony Tyrone Scott**, 32, shot in the chest by his wife in the presence of the wife's mother and stepfather

07/22/96 **Monquita Scott**, 19, shot by her boyfriend in the presence of their two year-old child. Her aunt, Beryl Murrill, was also killed and two other family members were injured

03/15/02 **Jessica Serwili**, 13, strangled by her sister's abusive husband after her sister filed a TPO and went into hiding

06/12/01 **Kelly Watt Snow**, 36, beaten and strangled to death by her husband in the presence of their infant son

04/04/00 **Tierra Sparks**, 16, shot to death in the back and chest by her ex-boyfriend, who also shot her mother in the head and chest; her mother survived the attack

07/07/00 **Robin Suzanne Steadman**, 28, shot in the head by her husband

10/25/03 **Ann Strickland**, 49, set on fire in her sleep by her boyfriend

08/22/03 **Annisha Sutton**, 24, 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

02/02/00 **Glenda Kay Terrell**, 43, stabbed to death by her sister's abusive husband; her sister survived being stabbed 14 times by her husband

10/12/03 **Debra Thomason**, 40, shot multiple times with an AK-47 assault rifle by her estranged husband

12/09/04 **Sabrina Thompson**, 28, stabbed by her daughter's father in the presence of her children. He later hanged himself in jail

06/09/02 **Ophelia Howard Tuff**, 39, shot in the head by her husband while trying to leave him for the first time; her sister was also shot twice in the head and once in the chest and survived

05/04/03 **Marissa J. Vaziri**, 27, strangled to death by her boyfriend of six weeks

07/23/04 **Adriana Vigil**, 19, shot in the face by her husband in the presence of three acquaintances

04/04/04 **Kimberly Hart Wilson**, 30, stabbed to death by her husband in the presence of the husband's co-worker

01/02/03 **Patricia Ann Wilson**, 35, strangled to death by her estranged husband

07/14/00 **Mary Kay Woodson**, 41, stabbed by her boyfriend outside of her apartment building less than three weeks after filing a TPO

07/24/07 **Name withheld**, 34, committed suicide after a long history of well-documented abuse by her husband