When Domestic Violence Kills

The Formation and Findings of the Denver Metro Domestic Violence Fatality Review Committee

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When Domestic Violence Kills

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Introduction

The nineteenth century French author Victor Hugo wrote of "an idea whose time has come." That concept is particularly applicable to domestic violence fatality review committees. Normally we associate ideas with a flash of brilliance, but in this case, the idea comes to us much like the first day of spring.

In October of 1998, Margaret Abrams, Dora Lee Larson and I attended the first National Conference on Domestic Violence Fatality Review sponsored in part by the National Council of Juvenile and Family Court Judges. We learned much during the three days conference and we were proud that Denver was one of the first regions in the country to have implemented a domestic violence fatality review board, having established one in 1996. However, we also realized that many of the issues, questions and solutions we faced, were faced by virtually all other domestic violence fatality review boards. It drove home a point that we already knew – that such boards are not the product of one great mind and are not peculiar to any one region or group of individuals. We remembered the many individuals back in Colorado who, at one time or another, put forth the idea of a domestic violence fatality review board, but that for one reason or another, the suggestion never came to fruition. The time for the idea was not right and the concept was as warmly received as a cold day in January.

In Colorado, the right time came as a result of the Petrosky case. The Petrosky case was a textbook example of the insidious nature of domestic violence. Unlike most other cases, where the woman suffers the brunt of physical violence and responding law enforcement and the public in general may suffer vicarious trauma, in this case not only did the woman bear the physical violence but the responding law enforcement and the public also suffered physical violence. To make matters worse, the violence suffered was the worst possible for everyone – death. The Petrosky case served as a graphic and tragic example of why we all need to take domestic violence more seriously. In doing this, we are saving not only the lives of those in the relationship, but also the lives of law enforcement and the community at large.

Another common theme discovered at the conference was that the impetus for most domestic violence fatality review committees is often generated by community agencies, but in order to be successful they need the
cooperation and participation of governmental agencies. This has been true for the Denver Metro Domestic Violence Fatality Review Committee as well. It is theorized that governmental agencies are reluctant to support the boards because they fear that they will be too critical and focus more on assessing blame than any thing else. Thus, virtually all boards, including Denver's, have vigorously attempted to avoid assessing blame in order to facilitate all agencies feeling comfortable with and invested in the process. This perspective must continue on with the Denver Metro Domestic Violence Fatality Review Committee.

This investment in the process is essential if any progress is to be made. Like a newly created garden on the first day of spring, the establishment of a domestic violence fatality review board brings with it a certain promise of hope for better times and change. While the reality of the garden in August may vary from the visions of April, the reality will not develop without the dedication of all. The garden must be tended by individuals invested in the ultimate outcome and the more diverse the individuals are, the healthier the garden will be. The efforts of a few will not produce as much as the efforts of many. Contributions must be made not only by community concerns, but also by governmental entities. By virtue of their positions, public servants owe the community the duty of thoughtful, active participation in the process to assess and better understand this most devastating type of domestic violence. While public servants might “come to the table” as a result of individual motivations, wherever possible public servant’s participation should be authorized and supported to act on behalf of the organization with which they are identified. If this approach is adopted by the Denver Metro Domestic Violence Fatality Review Committee, the harvest will be bountiful.

Brian T. Campbell
Denver County Court Judge
November, 2000
“...we want to believe that people are infinitely complex, with millions of motivations and varieties of behavior. It is not so. We want to believe that with all the possible combinations of human beings and human feelings, predicting violence is as difficult as picking the winning lottery ticket, yet it usually isn’t difficult at all. We want to believe that human violence is somehow beyond our understanding, because as long as it remains a mystery, we have no duty to avoid it, explore it, or anticipate it. We need feel no responsibility for failing to read signals if there are none to read. We can tell ourselves that violence just happens without warning, and usually to others, but in service of these comfortable myths, victims suffer and criminals prosper.”

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Denver Metro Domestic Violence Fatality Review Committee

Like all too many other communities, the Denver area was made painfully aware of the tragic affects of domestic violence with the death of Terry Petrosky. This time however, the community would do more than quietly grieve.

On a quiet Friday morning in April of 1995, Terry’s estranged husband walked into the grocery store where she had just arrived for work. Armed with a 9mm handgun, an assault rifle and a bolt-action rifle, he opened fire, fatally injuring Terry and wounding another employee. Store manager Dan Suazo tried to pull Terry to safety, only to be killed by Petrosky’s bullets in the process. Having found his intended target, Albert Petrosky backed out of the store, randomly spraying bullets. He returned to his vehicle, where he proceeded to set up a .30 SKS semi-automatic rifle on a tripod. His target would now be the first officer responding to the scene. Sergeant Timothy Mossbrucker had barely pulled into the parking lot before Petrosky riddled the patrol car with bullets, killing the Sergeant before he could even stop his patrol car, before he had even unholstered his gun.

Colorado has rightfully earned a reputation for working progressively and diligently on domestic violence issues. Yet, as the advocates, the judge, the therapist, and others came together to debrief and mourn the deaths of Terry Petrosky, Dan Suazo and Sgt. Tim Mossbrucker, all were haunted by the question: what more could have been done? What clues were there, if any, that could have foretold such a tragic outcome? Were indicators unrecognized? Like so many women before her, Terry did what she thought she needed to for her own and her son’s safety. She left the family home, attempting to stay out of Albert’s reach. She and her son went to counseling to seek support for a healthier, safer way of life. She accessed services and resources available to
battered women. She went to court for a restraining order against her abuser, and legal right to their son. However, she saw no other option than to be financially responsible and continue in a job where she had experienced success and support.

From these tragic beginnings came Colorado's first and only Domestic Violence Fatality Review Committee. Professionals from the Denver area were drawn together by these same compelling questions. Despite all the knowledge about domestic violence gained over the past two decades, there is clear acknowledgement that we still have much to understand to prevent these senseless deaths. While we continue to debate about risk factors in battering relationships, we are unable to predict which cases are more likely to escalate into fatalities. The ability to better identify the most lethal cases increases the likelihood of timely and more successful intervention.

There have been significant changes in recent years in law enforcement policies regarding response to domestic violence: legislation strengthening civil options and criminal penalties, and increased services for victims and perpetrators. At the same time, while other forms of violent crime are declining, the percentage of women killed by their intimate partner is not. A report issued by the Bureau of Justice Statistics in 1998 found that although women were less likely than men to experience violent crime in our society, they are 5 to 8 times more likely to be victimized by an intimate partner. They also reported that while the number of men killed by an intimate has dropped from 13.6% in 1976 to 8.8% of all homicides in 1996, the percentage of female victims killed by their male partners has consistently remained at 30% during this same time (Greenfeld et al., 1998). The development of a Domestic Violence Fatality Review process can be a critical avenue to reflect upon what is not yet working in our efforts to end violence against women in their own homes.

The concept of a domestic violence fatality review process has been discussed in the Denver community for years, but there was skepticism about the ability to bring the idea to reality. However, Colorado has convened a Child Fatality Review since 1989. The success of that Committee, in combination with the Petrosky and other high profile domestic fatalities, compelled Project Safeguard to bring together a core group to develop a fatality review model, and explore support and funding. Project Safeguard, an advocacy group for battered women, seemed the ideal entity to spearhead this project. As a non-profit, community-based agency, Safeguard was skilled in building cooperative coalitions. The agency's expertise with legal advocacy for battered women was built on relationships with the courts, law enforcement,
prosecution, shelters, perpetrator treatment, and others who would be an integral part of any productive process. While there was some initial concern about their community-based status hampering access to "in-system" information, it seemed reasonable that an outside agency could facilitate a broader discussion of a fatality review process and could promote an honest and non-defensive exchange of information. When funding became available through a collaborative grant with the Denver Police Department, the idea became a reality. Partnering with the Denver Police Department was an ideal way to achieve the vision of a domestic violence fatality review process, in conjunction with the Department's increased focus on domestic violence cases and the development of a specialized Domestic Violence Unit within the police department.

Mission Statement

The group began with defining a mission statement that would reflect the philosophy and purpose of the group. Everyone recognized the need to develop trust among members and promote the Committee as a place of honest exploration and learning. There was a commitment to examination without pointing fingers or assigning blame among those present or absent. A clear articulation of this philosophy and purpose was also necessary in gaining support and participation, especially from system based agencies. The Mission adopted by the Denver-Metro Domestic Violence Fatality Review Committee states:

"The purpose of this Committee is to investigate domestic violence related fatalities. Information will be collected, correlated and disseminated to create better understanding and education in the dynamics of domestic violence related fatalities, for future prevention. It is recognized that the perpetrators of domestic violence are ultimately responsible for the death of victims. Thus, the goal of this committee is not to place blame, but rather to better understand the dynamics of domestic violence when death is involved and thereby diminish the possibilities of future fatalities."

During informal debriefings of the Petrosky case, several issues emerged. First was recognition of the multitude of people in various systems and agencies who had bits and pieces of information about Albert Petrosky. Conversations with friends and acquaintances, prior arrests, probation contacts, threats made to others, information shared by Terry Petrosky, and contacts with various systems during the weeks
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preceding the deaths, all took on new perspective in hindsight. Had there been some way to put all the pieces of information together, a very different picture of the perpetrator would have emerged and an assessment of the danger would have been clearer. However, there was no vehicle to put the information into a coherent whole, and more importantly, this critical information was not available to the very people who were in a position to make intervening decisions: judges, law enforcement and victim advocates.

Secondly, was the more philosophical debate about whether or not such incidents and deaths are preventable, and how we have been paralyzed by the lack of satisfactory answers. The Petrosky case, among others, sparks the anxious speculation that there simply is no way to prevent or intervene with a perpetrator who is so focused on destruction. Some participants in the discussion felt that such cases are undetectable anomalies in otherwise effective work being done in the domestic violence community. However, it is clear that the work of this Domestic Violence Fatality Review Committee (hereafter referred to as the Committee) is predicated on a belief that many, if not all, domestic violence deaths are preventable, provided we continue the search for greater knowledge and understanding of the dynamics of domestic violence: sharing that knowledge with those most likely to be in a position to intervene. Unlike many other homicides, these are not characterized by random acts of violence, upon random or circumstantial victims. Compared to other homicides, intimate partner homicides are to some degree or another, calculated acts upon targeted victims.

Goals & Objectives

These two issues therefore became important not only in developing the mission statement, but also in defining the goals of the Committee. The goals of the Committee are:

- To cultivate and maintain committee membership of multidisciplinary expertise and can access information required for a productive review of domestic violence related fatalities.
- To create and maintain a comprehensive data base of the fatalities, assessing victim and perpetrator demographics, relationship history, prior abuse history, prior interventions and resources utilized, in order to further understand domestic violence homicide, and analyze what may provide more effective intervention.
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- To develop a risk assessment model, that would assist a broad spectrum of professionals in better identifying potentially lethal domestic violence perpetrators.
- To identify trends and patterns for policy recommendations regarding better communication and collaboration among agencies, and to develop earlier and more effective interventions in such cases.
- To develop and disseminate training materials to justice system personnel, domestic violence professionals and the community at large (such as clergy, attorneys, physicians, and employers) to help better assess dangerousness and identify effective intervention strategies.

While the Committee established ambitious goals for itself, the formation and functioning of the Committee has realized important benefits apart from the stated objectives. The Denver community has had the fortunate experience of working collaboratively on domestic violence issues for many years. However, the Committee has provided an important forum to increase communication and systemically examine the flow of information among responders to domestic violence cases. The core Committee was built on the existing network of domestic violence professionals. It has also provided an important avenue for broadening this network: bringing in professionals that were not previously involved directly in domestic violence policy development – the coroner, child protective services, and components of the health care community.

Committee Structure & Membership

Members for the Domestic Violence Fatality Review Committee were initially identified and recruited based on their access to necessary information. Given the Committee’s focus on the development of a comprehensive database, and subsequently a Risk Assessment Model, individuals who had expertise in research and domestic violence risk assessment were also recruited for membership. Therefore, the Committee is multi-disciplinary in nature, with members of varied education, training and experience. Given the broad scope of information sought, membership includes representatives from an array of services and disciplines that victims or perpetrators may contact, including but not limited to battered women advocates, perpetrator treatment providers, law enforcement, prosecution, judiciary, criminal justice victim assistance, psychologists, probation workers, child advocacy services, medical officials, child protective services and the
state-wide domestic violence coalition (for a complete list of members, see Appendix).

The success of the Committee relies on commitment and active participation. Therefore, it is requested that each participating agency designate a consistent representative to attend the meeting and any appropriate subcommittees. This is important for the sake of confidentiality as well as gaining an on-going knowledge and understanding of the Committee process and procedures. Members are responsible for sharing relevant information from their agency or discipline. While case-specific information remains confidential within the confines of the Committee, individual members also act as a liaison to their agency or professional discipline by helping to explain agency policies and identify areas for improved response. Additionally, members convey information or concerns back to their agency and assist with the development and implementation of policy recommendations made by the Committee.

When the Committee was first established, many individuals in the community expressed an interest in participation. The guidelines were developed to keep the Committee a workable size and have some objective rationale in defining membership. Interest alone could not be sufficient criteria. Committee composition required an analysis of what information was necessary for a productive review, where that information was likely to be, what outcome was desired (policy development, threat assessment, etc.) and what agencies or individuals could best contribute to the process. Agency representation and expectations of participation are outlined in a Memorandum of Understanding (See Appendix)

Project Safeguard administers and staffs the Committee through a Fatality Review Coordinator. This position is responsible for coordinating the various meetings, collecting initial information from appropriate criminal justice files, and maintaining the database of cases reviewed. Two co-chairs share facilitation and planning of the monthly meetings and the case review process. Modeled after the Denver Domestic Violence Task Force, there is a community-based and a system-based co-chair for the Domestic Violence Fatality Review Committee. This composition has proven beneficial in such collaborative efforts, by having shared leadership with diverse experiential, educational and sometimes philosophical backgrounds.

Due to our grant partnership with Denver Police Department, the initial focus of the Committee was Denver County; cases in which the domestic violence related fatality occurred in Denver. However, Denver County is
surrounded by three other counties and rapid population growth has expanded the metropolitan area to include several more. It is commonplace for a person to live in one county, work in another and have friends or family in multiple locations. A move of only a few miles often changes their county of residence. Given this geographic composition, it became clear early in the review process that it would not be unusual for a given perpetrator or victim to have had contact with multiple jurisdictions. The Committee became aware of several cases where the fatality occurred in a neighboring county, but Denver County had extensive contact with the perpetrator or victim, with records on previous arrests, restraining orders or probation contacts. Therefore, it was evident that coordination and collaboration with Denver's surrounding jurisdictions would be essential. Our most recent efforts to expand the committee metro-wide has required a modification of the initial structure, in order to keep the Committee a workable size and ensure information is accessed and available to all who need it.

The overall Committee meets bi-monthly; several sub-committees keep the tasks of the Committee moving forward. Some sub-committees were ad-hoc to help address initial organizational needs (e.g. to explore legal parameters of confidentiality, draw up a Confidentiality Agreement for members, create the data collection instrument) or other time-limited issues. The following standing sub-committees provide structure and organization to carry out the on-going work of the Committee.

**Executive Committee**

The primary focus is to guide the policy and protocol that regulates the Domestic Violence Fatality Review Committee. It is comprised of the two co-chairs and a core group of members representing each of the county jurisdictions as well as each of the standing committees. The subcommittee establishes policies and procedures for the overall functioning of the group; sets goals and direction; occasionally reviews the goals and objectives; addresses growth and policy needs; and planning tasks that the larger group would be unable to complete given the demands of the case review. This committee also addresses any legal issues, should they arise, or contact with the media. The Executive Committee meets quarterly, or more often as specific needs arise.

**Case Review Committee**

This group focuses on the fact-gathering and analysis of the cases reviewed. Members of this group have an interest in detailed analysis of the dynamics present in each case, as well as direct access to case-specific information. This committee is comprised of a core group of members who serve a two-year term, and floating members who are invited depending on the expertise or information required for a specific
case review. The core Case Review Committee is made up of three members from each of the participating jurisdictions, with representatives from each of the following disciplines: coroner, prosecutor, law enforcement, probation, system-based victim services, perpetrator treatment, social services and community-based victim services. The sub-committee Chair and the Fatality Review Coordinator determine what additional representatives are needed based on the case specifics. This may include law enforcement or victim assistance personnel who had contact with the case, or mental health providers or others who can address cultural, medical or mental health issues. The Case Review Committee meets monthly, ensures that all information required on each case is available and prepares a summary to be presented to the full Committee.

**Lethality / Risk Assessment Committee**

This subcommittee has been responsible for the development of a Risk Assessment Model (see Chapter 3 for model). The group stays current with other domestic violence risk assessment research and literature, reviews other tools being developed and helps review and refine the Committee's data collection process.

**Policy Implementation Committee**

Once recommendations have been identified by the Committee, this subcommittee provides follow-up and develops strategy for implementation. This may entail meeting with various agencies, researching current policy, protocol, or law; developing a legislative initiative or working with the Education and Training Committee to organize specific training for identified groups. This subcommittee meets bi-monthly, or as needed.

**Education and Training**

This subcommittee develops training materials; identifies professional groups for outreach and training; and helps carry out and organize training activities regarding domestic violence fatality, risk assessment and intervention.

**The Committee**

The full body meets every other month. Representatives from the Case Review subcommittee present the case summary information, identifying specific areas of inquiry such as relationship history, presence of prior domestic violence, criminal history, substance abuse history, mental health history and prior resources utilized (see Appendix for sample Case Summary). The Committee is comprised of agency
representatives who can influence policy development within their agency or professional discipline. This may be the same or different representative than those who participate in the various subcommittees. While the discussions at the Case Review Subcommittee are focused on understanding the history, dynamics and context of each individual case, the full Committee’s focus is on a better understanding of the patterns, trends and/or interventions presented by the cases reviewed. The Committee identifies and discusses recurring issues and can develop recommendations for improved policy or intervention. Issues requiring further follow up are referred to the Policy Implementation Committee, to ensure that the information and feedback is provided to the appropriate agency.

**Guests**

While there has been a commitment to consistent and stable membership, there is also the opportunity for “guests” to attend a Committee meeting. Interested individuals must request permission of one of the co-chairs and sign a Confidentiality Agreement. Guests may also be invited if they have information helpful to a specific case review or policy-related issue. However, it is understood that guests are not on-going members of the Committee and attend for a specific and legitimate purpose.

**Committee Interaction**

The structure of the Committee is established to utilize varied levels of expertise, from “front-line” workers with an understanding of dynamics and resources, to management executives who can leverage policy change. Building in a varied membership and working subcommittees also ensures the ability to carry out ideas and recommendations identified through the review process.

Issues that have been identified include physician reporting of abuse-related injuries, probation revocation criteria and process, and criteria and supervision of offenders on work-release. Researching these issues are beyond the scope of what can be accomplished in the full Committee meetings, but are appropriate issues for the Policy Implementation Subcommittee to follow up on. This subcommittee can research the specific information requested, meet with appropriate health care providers, probation and court staff. The subcommittee can identify and develop strategy for protocol development or implementation, if necessary. If there is a need for additional training or materials, this

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1 Colorado legislation passed in 1996 that mandates physicians report injuries resulting from domestic violence to law enforcement.
may also involve coordination with the Education and Training subcommittee. The following diagram details the structure and interaction of the various subcommittees.

Confidentiality

Individual or agency membership and participation on the Committee is strictly voluntary. Each member is required to sign a Confidentiality Agreement (see Appendix), which clarifies the expectation that any information learned about a particular case and subsequent discussion remain confidential within the group. Any documents shared at meetings are returned to and kept by the agency representative that brought the information. The experience of the Committee has been that as the trust level of the group has increased, information has flowed freely, without defensiveness. Members develop their own judgment and discretion regarding the information they share on specific cases as well as the policies of their specific agency or department.

Since there is no legislative authority for the establishment of a Fatality Review Committee in Colorado, certain obstacles arise. The lack of legislative sanction results in limited ability to access confidential material, particularly medical records. The review process may reveal
that a particular victim or perpetrator received medical or mental health treatment, but we are unable to gain any further detail. There are undoubtedly many cases we are unsuccessful in identifying that any treatment was obtained. Legislative authority could provide the committee subpoena power to access this type of documentation, or the participation of otherwise absent or recalcitrant individuals.

Equally important is the difficulty in shielding information gleaned in the case review process from civil or criminal discovery. In the absence of legislative protections, several safeguards have been implemented to minimize these risks. Most notably is the agreement that cases will not be reviewed until all litigation regarding criminal charges is resolved. This agreement allows the full participation of criminal justice personnel and access to their records. The Committee has also agreed to wait to review a case if there is any indication that civil litigation may arise. A letter of intent to sue a government agency must be filed within six months of an incident. In most cases, the criminal prosecution will take longer than this. Additional safeguards include maintaining the database by an assigned case number, not by name, and an agreement to only discuss and report information in aggregate form outside of the Committee meetings. These protections are important in building trust among the Committee members as well as remaining sensitive to surviving family and friends.

**Case Definition & Selection**

The Petrosky case clearly illustrated the need to look at case definition carefully. The incident greatly impacted the community and left behind many other homicide survivors in addition to Terry Petrosky’s family. There was a strong feeling among Committee members that to exclude Dan Suazo and Sergeant Mossbrucker in a count of domestic violence-related fatalities would eliminate vital pieces of information and perpetuate an inaccurate portrayal of domestic violence. Despite decades of work, there still exists the perception of domestic violence as a “family matter” and ambivalence about our right and obligation as a society to intervene and legislate sanctions. Yet this case, as well as others reviewed, clearly and tragically demonstrates the wide-reaching impact of domestic violence. By allowing this misperception to continue, the community remains at risk, regardless of an individual’s relationship to the victim or perpetrator. We miss the opportunity to understand and analyze who exactly is at risk as a ‘collateral’ victim, an intended victim or not.
The goal of the Committee has been to analyze intentional death that occurs within an intimate relationship. This includes all homicides of an intimate partner, as defined in Colorado statute and suicides that occur in the context of an intimate relationship. Thus, the cases reviewed include:

- Homicide in which the victim was a current or former intimate partner. (e.g. spouses, ex-spouses, boyfriend/girlfriend, former boyfriend/girlfriend, "common-law" and same-sex partners)

- Suicide of a perpetrator within the context of a domestic violence incident (suicide occurring after killing partner, following an assault or threat to the victim, and/or in the immediate vicinity of the victim or partner).

- "Murder by proxy": homicides that occur as a substitute to, or punishment of the partner (when a spouse or ex-spouse kills the child/ren or another family member as an act of revenge, or because they do not have access to the victim).

- Collateral homicides: the murder of other people that occur in the context of a domestic violence incident (such as new intimate partners, intervening friends, family or strangers, or responding law enforcement officers).

- Other circumstances where the identified perpetrator is killed, by a self-defending victim, bystander or law enforcement ("suicide by cop") in the context of a domestic violence incident.

Cases are identified through newspaper clippings as well as collaboration with local police departments. An annual list of these fatalities is compiled and the Fatality Review Coordinator tracks the criminal disposition. When there is no adjudication, in cases such as murder/suicide or determination of a self-defending victim, the review can occur fairly soon after the incident. On the other hand, criminal disposition typically takes 12 to 18 months.

While the review process occurs only in those cases of fatality that take place in the Denver metro area, Project Safeguard also tracks the incidence of domestic violence related fatalities statewide, in order to put the metro area fatalities in a broader context. (See Appendix for list of 1999 Domestic Violence Related Fatalities) Collecting accurate figures on the number of domestic violence homicides in Colorado, let alone the "collateral" fatalities, has proven a constant challenge. The Colorado Bureau of Investigation is mandated to track crime statistics in Colorado, including a break out of domestic violence homicides.
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statewide. However, due to differing definitions of relationships tracked and a lack of consistent reporting by local law enforcement jurisdictions, not even the figures reported by CBI give an accurate reflection of the deaths related to domestic violence. CBI's 1998 Annual Report identified 9 domestic violence homicides, as compared to the 35 identified by the Committee (28 of the 237 jurisdictions did not report any statistics to CBI in 1998). This does not include the eight collateral deaths the Committee identified, such as new partners who are killed in revenge, or intervening friends or extended family. Other studies (Davies, Lyon and Monti-Catania, 1998 and Hassler, Johnson and Websdale, 1999) have also identified additional intimate partner deaths through their review process, reinforcing the inaccuracy and limitations of most large databases that currently exist. For policy or legislative recommendations that may be based on figures in such databases, these inaccuracies need to be addressed.

The following chart tracks the domestic violence and related fatalities identified for the four-year period of time the Committee has been established. These numbers reflect the fatalities throughout Colorado, of which only a small portion have been reviewed by the Committee.
### Colorado Domestic Violence Related Fatalities

#### Table 1: Number of individual fatalities

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</tr>
</thead>
<tbody>
<tr>
<td>Intimate partner homicide</td>
<td>25</td>
<td>29</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Perpetrator Suicide</td>
<td>17</td>
<td>17</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Perpetrator killed: Other</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Non-partner DV-related homicides:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>New partners</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Other – (Includes law enforcement, co-workers, by-standers)</td>
<td>4</td>
<td>0</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Total Domestic Violence Related Fatalities</td>
<td>54</td>
<td>52</td>
<td>55</td>
<td>69</td>
</tr>
<tr>
<td>Total # Homicides Statewide</td>
<td>174</td>
<td>176</td>
<td>178</td>
<td>187</td>
</tr>
</tbody>
</table>

#### Table 2: Number of incidents / Type of crime

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Murder</td>
<td>12</td>
<td>20</td>
<td>26</td>
<td>29</td>
</tr>
<tr>
<td>Multiple homicide</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>0</td>
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<tr>
<td>Murder / Suicide</td>
<td>9</td>
<td>9</td>
<td>5</td>
<td>5</td>
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<tr>
<td>Multiple homicide/suicide</td>
<td>2</td>
<td>0</td>
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<tr>
<td>Attempted murder/suicide</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Murder / failed suicide</td>
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<td>Perpetrator Suicide</td>
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<td>3</td>
</tr>
<tr>
<td>Perpetrator Killed</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>7</td>
</tr>
</tbody>
</table>

(Reported by number of incidents, not individuals killed)
An analysis of these figures reveals that from 1996 to 1999, intimate partner homicide accounted for 14% to 20% of the total homicide rate. The inclusion of "collateral" homicides bumps this figure up to 19 to 37 percent. However, averaged over the three years, 45% of female homicide victims statewide were killed by an intimate partner. From the Committee's work, we know the statistics in Denver County are considerably lower. During 1999, 8.5 percent of homicides were committed by an intimate partner, with 29 percent of female homicide victims killed by an intimate partner. As the Committee expands the review process geographically, it will be important to determine if there are certain areas of the state experiencing a high incidence of domestic violence fatalities consistently, and if there are any correlations with the policies in place and/or the availability of resources to victims or perpetrators.

National statistics (given the limitations and inaccuracies just discussed) indicate intimate partner homicide accounts for a relatively small percentage of homicides – about 9% nationally. However, they do account for a significant portion of female homicide victims. Therefore addressing factors to decrease intimate partner homicide may only make a small change in the overall homicide rate, but can make a large difference in the female homicide rate and percentage of intimate partner homicide. A study in Detroit on homicide trends over a ten year period saw a decrease of 7% in homicide, while intimate / family violence decreased by 37% during this time. (Pamela K. Lattimore et al, 1997)

**Gender Differences**

A discussion of cases selection and definition would not be complete without addressing gender differences in who kills whom and the motivations and circumstances in intimate partner homicide. While the intent of the analysis is to gain an understanding of why women continue to be killed at an alarming rate in intimate relationships, the sample includes both male and female perpetrators of intimate partner homicide.

Research findings suggest that men and women have different reasons for killing their intimates and different circumstances surrounding the actual act. Studies have found that women tend to kill during domestic disputes (Browne, 1997; Goetting, 1991; Jurik and Winn, 1990; Maguigan, 1991). Women typically kill after experiencing a long history of physical and psychological abuse at the hands of their intimate male partner (Browne, 1987; Campbell, 1995; Ewing, 1987; Goetting, 1991; Morton et al., 1998; Walker, 1989; Wilson and Daly, 1993). Women, more often than men, claim self-defense in the killing of their intimate partners (Cazenave and Zahn, 1992; Jurik and Winn, 1990). In addition,
when women kill male intimates (far more often than when men kill female intimates) it is after the “victim” initiated the deadly encounter by threats of force or with use of physical force against their partners or ex­partners (Campbell, 1992; Campbell, 1995; Cazenave and Zahn, 1992; Jurik and Winn, 1990). Although both men and women are most likely to use a firearm in the killing of their intimate partner, women are more likely than men to use common household items as weapons, such as kitchen knives (Cazenave and Zahn, 1992; Jurik and Winn, 1990). This may be an attempt by women to “level the playing field” against men who may be physically stronger and bigger than they are. Moreover, it may speak to the fact that women are more likely than men to react in self-defense (Cazenave and Zahn, 1992).

Men who kill their partners often have a history of abuse toward their female partners (Campbell, 1992; Goetting, 1991; McFarlane et al., 1999; Wilson and Daly, 1993). Campbell (1992) found that of the 28 women in her study killed by their husbands, 18 of them, or 64 percent were known to have been physically abused by their husbands prior to their death. Motivations that Campbell cited for these killings included: male jealousy, male dominance, and victim precipitation (although this occurred rarely with male perpetrators and much more commonly with female ones) (Campbell, 1992). In addition, men are much more likely than women to commit homicide/ suicide (Morton et al., 1998). In other words, they are more likely to kill their female partners or ex-partners and then kill themselves.

**Data Collection Tool**

Development of the data collection tool occurred with several issues in mind. First and foremost was the desire to gain a better understanding of the context within which the fatality occurs. We wanted to collect information not just on the incident in which the fatality occurred, but any indications of past abuse, and the psychosocial, relationship and criminal history of the individuals involved. Given that one of the goals of the Committee is to develop a Risk Assessment Model, information is collected on factors that may indicate risk of lethality, as indicated in research literature as well as the collective experience of Committee members. A related area of exploration is what previous disclosures of abuse occurred, and to whom they were disclosed. To identify possible points of intervention, it becomes important to know what those sources are, and not make assumptions about resources utilized (or not).

There also was a desire to look at “intervention” in broad terms - not limiting it to formal / criminal justice system intervention only. While
these systems may have the most prescribed means of providing intervention and imposing sanctions, to ignore other avenues of intervention such as family, employers, health care providers or clergy, would be to ignore important, and perhaps more common avenues of identification and help-seeking behavior by victims. Research has indicated that most battered women engage in a variety of help-seeking behavior, with police involvement occurring only later in the relationship with increased severity of abuse. Therefore, possible points of earlier intervention may especially be overlooked if intervention is defined in narrow terms.

All of this is tempered by the limitations of information available to the Committee. Some information believed to be important to an analysis of the case and associated risks, simply is not consistently available. Factors such as prior mental health treatment, suicidal threats and/or attempts are often not available due to confidentiality, or the fact that is unknown to any documented source. The review process often revealed clues that family, friends or co-workers had concerns, but the Committee thus far, does not have a means to follow up in determining the specifics of what may have been disclosed to them.

Consistent with the mission statement and philosophy that the fatality is ultimately the perpetrator’s responsibility, the Data Collection Tool is designed to collect information on the perpetrator first. The perpetrator’s dynamics must remain the focus of the Committee’s scrutiny. Prior studies clearly show that the primary risk factor for being victimized is being female. Looking at factors associated with the victim is for the purpose of understanding the context of the relationship and resources accessed. The risk factors identified are assessed in light of the perpetrator’s history and characteristics, not the victim’s. To do otherwise encourages victim-blaming and dilutes the focus.

**Missing Data – Deficiencies in the Data**

Critical to the case review discussion is an awareness of what information was not obtained and why, and how those gaps in information may influence the Committee’s findings and subsequent recommendations. There are several factors that affect the ability to gather complete information. These include limited or absent information about prior abuse and help seeking behavior of the victim; lack of access to records documenting the perpetrator’s history (medical, mental health, school or service); inability to get direct information from the perpetrator regarding his motivations and inability to get direct information from surviving friends or family, who often have insight into
the events preceding the fatality. Some of these limitations are dictated by statutory or logistical factors, some by the lack of staff or funding resources of the Committee.

The information gathered relies on the assumption that there has been some formalized system contact with the perpetrator or victim. The review process is dependant on the availability of documentation from law enforcement, the criminal or civil justice system, probation or some identified community-based agency. However piecing the information together is often like walking a maze and requires multiple checks to ensure information is not missed.

Coordinated technology does not exist in the criminal justice system, either within or across jurisdictions. A thorough check of prior arrests is conducted in each case, but there are often gaps in the databases utilized. Many domestic violence arrests in the Denver-metro area occur as municipal ordinance violations, which are not always entered into the databases available to criminal justice personnel outside of that particular jurisdiction. In some jurisdictions, what is charged at the municipal level may be charged as a state crime in another. Therefore, looking at the specifics of each offense became important in determining the extent and nature of prior documented abuse.

The Committee has implemented a process to re-check information with each of the local jurisdictions, but the possibility still exists that the information collected under estimates the presence or number of arrests. In situations where the perpetrator recently moved to Colorado, this may be even more of an issue, as other state’s records may not be fully accessible.

Informed consent requirements are a consistent contributor to missing information. Medical and mental health records are almost always out of bounds, even if it is known that the perpetrator or victim sought treatment. If treatment was voluntarily sought, knowledge of these files does not exist. The Committee has implemented procedures to obtain the appropriate releases when use of the services is identified, but it can only be presumed that information from these sources is missing.

The agreement to access only closed cases has been a limitation in some circumstances. While the vast majority of crimes are adjudicated, those cases where the perpetrator remains at large or an intimate partner is the primary suspect, but not charged, are beyond our purview. There have also been a handful of cases where domestic violence was suspected as an underlying factor in a case, but the partner either was not charged
or acquitted of charges. If or how it may be appropriate to review these deaths remain a topic of debate among the Committee.

While many of the cases did have contact with some system, many did not. In these circumstances, the only information available is that gleaned in the homicide investigation. Cases in which the perpetrator committed suicide often had very limited information, especially when there was no prior criminal history. In these cases, the homicide investigation is focused on resolving the crime and confirming that the case is truly a murder/suicide. Often this does not include much documentation about the relationship history, mental health issues, etc.; issues that would typically be more fully investigated if there is doubt about the identity of the perpetrator, or in preparation for trial.

In cases where the only documentation is the homicide investigation, information must be assessed with the awareness that certainly the perpetrator’s accounting of the information, and often other witnesses recounting of events will be biased. Gaining accurate information about some of the factors the Committee is seeking, such as prior history of abusive behavior, previous disclosures made or resources utilized, may be seriously colored in response to the crime, family or friend’s grief reactions or their relationship to the perpetrator or victim. As criminal justice system personnel is well aware, it is not unusual to have conflicting or contradictory information.

Perhaps the biggest, and most critical pieces of missing data are those variables aimed at assessing previous disclosures of abuse and help-seeking behavior by the victim. Clearly the victim is no longer able to give us her own assessment of danger from the perpetrator, conversations she may have had with others in an attempt to sort through concerns, or other community resources she may have accessed. Friends, family and neighbors interviewed during the homicide investigation often provided the best insight into these variables, but unless their comments or information seem directly relevant to the investigation, they may not be documented in much detail, if at all. There are additional people, such as co-workers, health care providers or clergy, who knew the victim and/or perpetrator who are outside the scope of the immediate investigation, who could also shed light on these issues. However, at this time, the Committee has not been able to incorporate a way to access those individuals to ensure a completely accurate assessment of these factors.

Therefore, the findings and subsequent recommendations are based on the information obtained, with a clear realization that information we felt important to a thorough case review is missing in some cases. Some
of the factors we feel are critical to an understanding and assessment of risk, such as prior or recent suicidal behavior. Other information obtained sporadically, such as education or employment may not be as critical, but its absence prevents our gaining a complete picture of the perpetrator and determination of the significance of these variables. However, based on the information we do have, some significant issues and trends have emerged.
Domestic Violence Fatality Review
Case Findings

Table 1. Case Descriptions

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
<th>(n)</th>
</tr>
</thead>
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<td><strong>Year</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1993</td>
<td>5.4</td>
<td>(2)</td>
<td></td>
</tr>
<tr>
<td>1994</td>
<td>10.8</td>
<td>(4)</td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td>18.9</td>
<td>(7)</td>
<td></td>
</tr>
<tr>
<td>1996</td>
<td>27.0</td>
<td>(10)</td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>24.3</td>
<td>(9)</td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>13.5</td>
<td>(5)</td>
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<tr>
<td><strong>Type of Crime</strong></td>
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<td></td>
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<tr>
<td>Homicide</td>
<td>54.1</td>
<td>(20)</td>
<td></td>
</tr>
<tr>
<td>Homicide/Suicide</td>
<td>29.7</td>
<td>(11)</td>
<td></td>
</tr>
<tr>
<td>Attempted Homicide/Suicide</td>
<td>16.2</td>
<td>(6)</td>
<td></td>
</tr>
<tr>
<td><strong>Number of Homicide Victims</strong></td>
<td>34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>8.1</td>
<td>(6)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>81.1</td>
<td>(30)</td>
<td></td>
</tr>
<tr>
<td>2-3</td>
<td>13.5</td>
<td>(4)</td>
<td></td>
</tr>
<tr>
<td><strong>Victim’s Cause of Death</strong></td>
<td>31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gunshot</td>
<td>54.8</td>
<td>(17)</td>
<td></td>
</tr>
<tr>
<td>Stabbing</td>
<td>19.4</td>
<td>(6)</td>
<td></td>
</tr>
<tr>
<td>Beating</td>
<td>16.1</td>
<td>(5)</td>
<td></td>
</tr>
<tr>
<td>Asphyxiation</td>
<td>3.2</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>Strangulation</td>
<td>6.5</td>
<td>(2)</td>
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*Variable*
WHEN DOMESTIC VIOLENCE KILLS

<table>
<thead>
<tr>
<th>Perpetrator's Cause of Death&lt;sup&gt;b&lt;/sup&gt;</th>
<th>19</th>
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<tbody>
<tr>
<td>Suicide</td>
<td>94.7 (18)</td>
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<td>Killed in Confrontation with Police</td>
<td>5.3 (1)</td>
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<table>
<thead>
<tr>
<th>Type of Weapon Used&lt;sup&gt;c&lt;/sup&gt;</th>
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</thead>
<tbody>
<tr>
<td>Firearm</td>
<td>64.5 (20)</td>
</tr>
<tr>
<td>Knife</td>
<td>25.8 (8)</td>
</tr>
<tr>
<td>Bat, Board, Blunt Object</td>
<td>3.2 (1)</td>
</tr>
<tr>
<td>Other&lt;sup&gt;d&lt;/sup&gt;</td>
<td>6.5 (2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Place of Crime</th>
<th>37</th>
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</thead>
<tbody>
<tr>
<td>Victim and Offender Joint Home</td>
<td>48.6 (18)</td>
</tr>
<tr>
<td>Victim's residence</td>
<td>16.2 (6)</td>
</tr>
<tr>
<td>Offender's residence</td>
<td>5.4 (2)</td>
</tr>
<tr>
<td>Other's residence</td>
<td>2.7 (1)</td>
</tr>
<tr>
<td>Victim's work site</td>
<td>2.7 (1)</td>
</tr>
<tr>
<td>Public space</td>
<td>21.6 (8)</td>
</tr>
<tr>
<td>Other</td>
<td>2.7 (1)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Characteristics of Case&lt;sup&gt;e&lt;/sup&gt;</th>
<th>32</th>
<th>6.3 (2)</th>
</tr>
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<tbody>
<tr>
<td>Divorce/Custody Pending at DOD</td>
<td>32</td>
<td>6.3 (2)</td>
</tr>
<tr>
<td>Witnesses to Incident</td>
<td>37</td>
<td>51.4 (19)</td>
</tr>
<tr>
<td>Offender Blood Alcohol Content Positive&lt;sup&gt;f&lt;/sup&gt;</td>
<td>23</td>
<td>47.8 (11)</td>
</tr>
<tr>
<td>Victim Blood Alcohol Content Positive</td>
<td>36</td>
<td>27.8 (10)</td>
</tr>
<tr>
<td>Offender Drug Metabolite Present&lt;sup&gt;g&lt;/sup&gt;</td>
<td>21</td>
<td>38.0 (8)</td>
</tr>
<tr>
<td>Victim Drug Metabolite Present</td>
<td>36</td>
<td>13.9 (5)</td>
</tr>
</tbody>
</table>

<sup>a</sup> Six victims survived, thus N=31 for this variable
<sup>b</sup> Nineteen perpetrators did not survive, this N=19 for this variable
<sup>c</sup> 31 out of the 37 cases involved a weapon.
<sup>d</sup> Other types of weapons included a telephone and concrete rebar.
<sup>e</sup> Each of the following categories is its own variable, thus a case could feasibly involve all categories.
<sup>f</sup> BAC tests were conducted on only 23 offenders and 36 victims
<sup>g</sup> 23 offenders and 36 victims had this test.
### Table 2. Offender Characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>37</td>
<td>86.5</td>
<td>(32)</td>
</tr>
<tr>
<td>Female</td>
<td>13.5</td>
<td>(5)</td>
<td></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 and Under</td>
<td>13.5</td>
<td>(5)</td>
<td></td>
</tr>
<tr>
<td>26-40</td>
<td>37.8</td>
<td>(14)</td>
<td></td>
</tr>
<tr>
<td>41-55</td>
<td>37.8</td>
<td>(14)</td>
<td></td>
</tr>
<tr>
<td>Over 55</td>
<td>10.8</td>
<td>(4)</td>
<td></td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
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<td></td>
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<tr>
<td>White</td>
<td>35.1</td>
<td>(13)</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>24.3</td>
<td>(9)</td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>29.7</td>
<td>(11)</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>8.1</td>
<td>(3)</td>
<td></td>
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<tr>
<td>Native American</td>
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<td></td>
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<tr>
<td><strong>Employment Status</strong></td>
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<tr>
<td>Employed</td>
<td>47.1</td>
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</tr>
<tr>
<td>Unemployed</td>
<td>35.3</td>
<td>(12)</td>
<td></td>
</tr>
<tr>
<td>Retired</td>
<td>8.8</td>
<td>(3)</td>
<td></td>
</tr>
<tr>
<td>Disabled</td>
<td>5.9</td>
<td>(2)</td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>2.9</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td><strong>Education Level</strong></td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some High School</td>
<td>50.0</td>
<td>(9)</td>
<td></td>
</tr>
<tr>
<td>High School Graduate</td>
<td>16.7</td>
<td>(3)</td>
<td></td>
</tr>
<tr>
<td>Some College</td>
<td>16.7</td>
<td>(3)</td>
<td></td>
</tr>
<tr>
<td>Post Graduate</td>
<td>5.6</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>Technical School</td>
<td>11.1</td>
<td>(2)</td>
<td></td>
</tr>
<tr>
<td><strong>Suicide History</strong></td>
<td>37</td>
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<td></td>
</tr>
<tr>
<td>Evidence of Prior Threats of Suicide</td>
<td>32.4</td>
<td>(12)</td>
<td></td>
</tr>
<tr>
<td>Evidence of Prior Suicide Attempts</td>
<td>13.5</td>
<td>(5)</td>
<td></td>
</tr>
</tbody>
</table>

---

* Offenders' ages ranged from 17 to 79 years old. The mean age was 41.0, the median age 40.0, and the modal age 34.

* Based on total N. If anything, these statistics underestimate rates. Reported are the cases we could confirm evidence of prior attempts and threats of suicide.
Table 3. Offender's Criminal History

<table>
<thead>
<tr>
<th>Variable</th>
<th>%</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence of Prior Criminal Involvement</td>
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<td></td>
</tr>
<tr>
<td>Evidence of DV in Prior Relationships</td>
<td>21.6</td>
<td>(8)</td>
</tr>
<tr>
<td>Prior DV Arrest</td>
<td>43.2</td>
<td>(16)</td>
</tr>
<tr>
<td>Prior Arrests for Other Assaults</td>
<td>54.1</td>
<td>(20)</td>
</tr>
<tr>
<td>Received DV Treatment</td>
<td>21.6</td>
<td>(8)</td>
</tr>
<tr>
<td>Prior DUI/Drug Possession Arrest</td>
<td>48.6</td>
<td>(18)</td>
</tr>
<tr>
<td>Prior Substance Treatment</td>
<td>21.6</td>
<td>(8)</td>
</tr>
<tr>
<td>Prior Investigation/Arrest for Child Abuse</td>
<td>13.5</td>
<td>(5)</td>
</tr>
<tr>
<td>Juvenile Record</td>
<td>32.4</td>
<td>(12)</td>
</tr>
<tr>
<td>Arrests for RO Violations</td>
<td>13.5</td>
<td>(5)</td>
</tr>
<tr>
<td>Probation Revocation Requested</td>
<td>21.6</td>
<td>(8)</td>
</tr>
</tbody>
</table>

Number of DV Arrests in Past 5 Years

<table>
<thead>
<tr>
<th>Number of DV Arrests in Past 5 Years</th>
<th>%</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>54.1</td>
<td>(20)</td>
</tr>
<tr>
<td>1-2</td>
<td>18.9</td>
<td>(7)</td>
</tr>
<tr>
<td>3-4</td>
<td>16.2</td>
<td>(6)</td>
</tr>
<tr>
<td>5-8</td>
<td>8.1</td>
<td>(3)</td>
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</tbody>
</table>

Number of Other Arrests in Past 5 Years

<table>
<thead>
<tr>
<th>Number of Other Arrests in Past 5 Years</th>
<th>%</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>40.5</td>
<td>(15)</td>
</tr>
<tr>
<td>1-2</td>
<td>24.3</td>
<td>(9)</td>
</tr>
<tr>
<td>3-4</td>
<td>13.5</td>
<td>(5)</td>
</tr>
<tr>
<td>5-22</td>
<td>16.2</td>
<td>(6)</td>
</tr>
</tbody>
</table>

---

*a Based on the total N. If anything, these statistics underestimate rates. Reported are the cases we could confirm a criminal history.

*b Each of the following categories is its own variable, thus each case could feasibly involve all categories.

*c There were only 12 cases where there was documentation of a restraining order.

*d There were only 20 cases where probation was indicated in the offender's history.

*e The mean number of DV arrests in the past 5 years was 1.3, the median 0, and the mode 0.

*f The mean number of other arrests for non-DV assault, harassment, disturbance or menacing in the past 5 years was 2.3, the median 1.0, and the mode 0 (Did not include property crimes).
### Table 4. Victim Characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>37</td>
<td>16.2</td>
<td>(6)</td>
</tr>
<tr>
<td>Female</td>
<td>83.8</td>
<td>(31)</td>
<td></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 and Under</td>
<td>37</td>
<td>21.6</td>
<td>(8)</td>
</tr>
<tr>
<td>26-40</td>
<td></td>
<td>32.4</td>
<td>(12)</td>
</tr>
<tr>
<td>41-55</td>
<td></td>
<td>37.8</td>
<td>(14)</td>
</tr>
<tr>
<td>Over 55</td>
<td></td>
<td>8.1</td>
<td>(3)</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>37</td>
<td>37.8</td>
<td>(14)</td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
<td>16.2</td>
<td>(6)</td>
</tr>
<tr>
<td>African American</td>
<td></td>
<td>32.4</td>
<td>(12)</td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td>10.8</td>
<td>(4)</td>
</tr>
<tr>
<td>Native American</td>
<td></td>
<td>2.7</td>
<td>(1)</td>
</tr>
<tr>
<td><strong>Employment Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>28</td>
<td>57.1</td>
<td>(16)</td>
</tr>
<tr>
<td>Unemployed</td>
<td></td>
<td>25.0</td>
<td>(7)</td>
</tr>
<tr>
<td>Retired</td>
<td></td>
<td>10.7</td>
<td>(3)</td>
</tr>
<tr>
<td>Disabled</td>
<td></td>
<td>3.6</td>
<td>(1)</td>
</tr>
<tr>
<td>Student</td>
<td></td>
<td>3.6</td>
<td>(1)</td>
</tr>
<tr>
<td><strong>Victim Economic Support (if unemployed)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AFDC/SSI/Public Assistance</td>
<td>7</td>
<td>42.9</td>
<td>(3)</td>
</tr>
<tr>
<td>Perpetrator</td>
<td></td>
<td>28.6</td>
<td>(2)</td>
</tr>
<tr>
<td>Assistance from Family or Friends</td>
<td></td>
<td>14.3</td>
<td>(1)</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>14.3</td>
<td>(1)</td>
</tr>
<tr>
<td><strong>Victims’ Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some High School</td>
<td>14</td>
<td>42.9</td>
<td>(6)</td>
</tr>
<tr>
<td>High School Graduate</td>
<td></td>
<td>21.4</td>
<td>(3)</td>
</tr>
<tr>
<td>Some College</td>
<td></td>
<td>21.4</td>
<td>(3)</td>
</tr>
<tr>
<td>Post Graduate</td>
<td></td>
<td>7.1</td>
<td>(1)</td>
</tr>
<tr>
<td>Technical School</td>
<td></td>
<td>7.1</td>
<td>(1)</td>
</tr>
<tr>
<td><strong>Children From Previous Relationship</strong></td>
<td>27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
<td>48.1</td>
<td>(13)</td>
</tr>
</tbody>
</table>
Victims' ages ranged from 18 to 85 years old. The mean age of the primary victim was 39.5, the median 39.0, and the mode 47.

The N is only 7 because data for this variable were only collected for unemployed victims.

* The mean number of children from a previous relationship was 7.8, the median 1.0, and the mode 0.

### Table 5. Characteristics of Victim-Offender Relationship

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationship</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Spouse/Partner (cohabiting)</td>
<td>37</td>
<td>67.6</td>
<td>(25)</td>
</tr>
<tr>
<td>Former Spouse/Partner</td>
<td></td>
<td>27.0</td>
<td>(10)</td>
</tr>
<tr>
<td>Dating (never cohabited)</td>
<td></td>
<td>2.7</td>
<td>(1)</td>
</tr>
<tr>
<td>Ex-Dating</td>
<td></td>
<td>2.7</td>
<td>(1)</td>
</tr>
<tr>
<td><strong>Length of Relationship a</strong></td>
<td>36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 1 year</td>
<td></td>
<td>11.1</td>
<td>(4)</td>
</tr>
<tr>
<td>1-3 years</td>
<td></td>
<td>36.1</td>
<td>(13)</td>
</tr>
<tr>
<td>More than 3 years</td>
<td></td>
<td>52.8</td>
<td>(19)</td>
</tr>
<tr>
<td><strong>Number of Children by This Relationship b</strong></td>
<td>36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
<td>66.7</td>
<td>(24)</td>
</tr>
<tr>
<td>1-2</td>
<td></td>
<td>16.7</td>
<td>(6)</td>
</tr>
<tr>
<td>3 or more</td>
<td></td>
<td>16.7</td>
<td>(6)</td>
</tr>
<tr>
<td><strong>Pregnant at the DOD c</strong></td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td>10.0</td>
<td>(3)</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>90.0</td>
<td>(27)</td>
</tr>
<tr>
<td><strong>First Pregnancy</strong></td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td>33.3</td>
<td>(1)</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>66.7</td>
<td>(2)</td>
</tr>
</tbody>
</table>

* The length of relationship ranged from 3 to 672 months. The mean number of months in the relationship was 123.0, the median 39.0, and the mode 36.
The number of children from this relationship ranged from 0 to 5. The mean number of children from this relationship was 3.5, the median 0, and the mode 0.

This analysis was conducted only on the female victims. Of the 31 female victims, pregnancy status was known for 30.

**Table 6. Issues Surrounding Domestic Violence in the Relationship**

<table>
<thead>
<tr>
<th>Variable</th>
<th>%</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evidence of Prior DV in the Relationship</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal Harassment</td>
<td>56.8</td>
<td>(21)</td>
</tr>
<tr>
<td>Pushing, Grabbing, Shoving, Slapping</td>
<td>59.5</td>
<td>(22)</td>
</tr>
<tr>
<td>Destruction of Property/Throwing Things</td>
<td>24.3</td>
<td>(9)</td>
</tr>
<tr>
<td>Punching, Kicking, Biting</td>
<td>35.1</td>
<td>(13)</td>
</tr>
<tr>
<td>Choking</td>
<td>13.5</td>
<td>(5)</td>
</tr>
<tr>
<td>Forced Sex/Obsessive Sexual Behaviors</td>
<td>18.9</td>
<td>(7)</td>
</tr>
<tr>
<td>Cruelty/Injury to Pets</td>
<td>2.7</td>
<td>(1)</td>
</tr>
<tr>
<td>Isolation</td>
<td>35.1</td>
<td>(13)</td>
</tr>
<tr>
<td>Alcohol Abuse by Perpetrator</td>
<td>37.8</td>
<td>(14)</td>
</tr>
<tr>
<td>Drug Abuse by Perpetrator</td>
<td>18.9</td>
<td>(7)</td>
</tr>
<tr>
<td>Perpetrator Suicide Threat</td>
<td>16.2</td>
<td>(6)</td>
</tr>
<tr>
<td>Threats to Kill Victim</td>
<td>37.8</td>
<td>(14)</td>
</tr>
<tr>
<td>Threats to Kill Others</td>
<td>13.5</td>
<td>(5)</td>
</tr>
<tr>
<td>Threats to use Weapon on Victim</td>
<td>21.6</td>
<td>(8)</td>
</tr>
<tr>
<td>Threats with/Use of/Weapon</td>
<td>16.2</td>
<td>(6)</td>
</tr>
<tr>
<td>Tracking, Following</td>
<td>43.2</td>
<td>(16)</td>
</tr>
<tr>
<td>Other Abuse</td>
<td>18.9</td>
<td>(7)</td>
</tr>
<tr>
<td><strong>Prior Medical Treatment Due to DV</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim Filed TRO/PRO</td>
<td>18.9</td>
<td>(7)</td>
</tr>
<tr>
<td><strong>Disclosure of DV Prior to Incident</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DV Report to Police</td>
<td>40.5</td>
<td>(15)</td>
</tr>
<tr>
<td>DV Report to Medical</td>
<td>24.3</td>
<td>(9)</td>
</tr>
<tr>
<td>DV Report to Family Members</td>
<td>51.4</td>
<td>(19)</td>
</tr>
<tr>
<td>DV Report to Clergy</td>
<td>2.7</td>
<td>(1)</td>
</tr>
<tr>
<td>DV Report to Friends/Co-workers</td>
<td>29.7</td>
<td>(11)</td>
</tr>
<tr>
<td>DV Report to Neighbors</td>
<td>21.6</td>
<td>(8)</td>
</tr>
<tr>
<td>DV Report to Shelter/DV Program</td>
<td>10.8</td>
<td>(4)</td>
</tr>
<tr>
<td>DV Report to Civil Court</td>
<td>13.5</td>
<td>(5)</td>
</tr>
<tr>
<td>DV Report to Social Services</td>
<td>10.8</td>
<td>(4)</td>
</tr>
<tr>
<td>DV Report to Attorney/Legal Services</td>
<td>10.8</td>
<td>(4)</td>
</tr>
</tbody>
</table>
When Domestic Violence Kills

- Based on the total N. If anything, these statistics significantly underestimate rates. Reported are the cases we could confirm a history of domestic violence and some details of prior abuse.

### Table 7. Possible Indications of Victim Attempts to End Violence / Relationship and Situational Precursors

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Victim/Perpetrator Separated on DOD</strong></td>
<td>37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>35.1</td>
<td>(13)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>45.9</td>
<td>(17)</td>
<td></td>
</tr>
<tr>
<td>Separation Imminent</td>
<td>18.9</td>
<td>(7)</td>
<td></td>
</tr>
<tr>
<td><strong>Number of Weeks Separated at DOD</strong></td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-3 weeks</td>
<td>38.5</td>
<td>(5)</td>
<td></td>
</tr>
<tr>
<td>4-14 weeks</td>
<td>23.1</td>
<td>(3)</td>
<td></td>
</tr>
<tr>
<td>15+ weeks</td>
<td>38.5</td>
<td>(5)</td>
<td></td>
</tr>
<tr>
<td><strong>History of Separation</strong></td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>82.6</td>
<td>(19)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>17.4</td>
<td>(4)</td>
<td></td>
</tr>
<tr>
<td><strong>Number of Previous Separations</strong></td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>16.7</td>
<td>(3)</td>
<td></td>
</tr>
<tr>
<td>1-2</td>
<td>55.6</td>
<td>(10)</td>
<td></td>
</tr>
<tr>
<td>3+</td>
<td>27.8</td>
<td>(5)</td>
<td></td>
</tr>
<tr>
<td><strong>Change in Victim-Offender-Relationship</strong></td>
<td>29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>82.8</td>
<td>(24)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>17.2</td>
<td>(5)</td>
<td></td>
</tr>
<tr>
<td><strong>Change in Residence in Previous Year</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim Moved Out</td>
<td>28</td>
<td>46.4</td>
<td>(13)</td>
</tr>
<tr>
<td>Victim Asked Perpetrator to Move Out</td>
<td>22</td>
<td>36.4</td>
<td>(8)</td>
</tr>
<tr>
<td>Change in Perpetrator’s Residence</td>
<td>22</td>
<td>27.3</td>
<td>(6)</td>
</tr>
<tr>
<td><strong>Victim-Initiated Reports/Behaviors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim Initiated Legal Action</td>
<td>26</td>
<td>26.9</td>
<td>(7)</td>
</tr>
<tr>
<td>Victim Had Desire to Leave</td>
<td>24</td>
<td>75.0</td>
<td>(18)</td>
</tr>
<tr>
<td>Victim Told Perpetrator of Desire to Leave</td>
<td>22</td>
<td>63.6</td>
<td>(14)</td>
</tr>
<tr>
<td>Victim told Others of Desire to Leave</td>
<td>19</td>
<td>52.6</td>
<td>(10)</td>
</tr>
</tbody>
</table>
WHEN DOMESTIC VIOLENCE KILLS

Victim Entered DV Counseling 19 15.8 (3)
Victim took other Steps to Leave 5 80.0 (4)

Changes in Perpetrator's Life
Change in Perpetrator's Physical Health 15 20.0 (3)
Change in Perpetrator's Mental Health 14 42.9 (6)
Change in Perpetrator's Employment/Finances 15 46.7 (7)
Other Losses in Perpetrator's Life 8 37.5 (3)
Other Changes in Perpetrator's Life 12 58.3 (7)

These statistics only involve those 13 cases where the victim and the perpetrator were separated at the DOD. The number of weeks separated ranged from 1 to 72 weeks. Of those cases, the mean number of weeks separated was 16.6, the median 4.0, and the mode 1.

These statistics only involve those 18 cases, where the victim and perpetrator had a history of separation identified. The number of times separated ranged from 1 to 5, and is likely to be under-estimated. Of those cases, the mean number of times separated was 2.5, the median 2.0, and the mode 2.

This only includes cases where these reports could be verified, thus, if anything, they likely under-estimate the prevalence of victims' actions of these sorts.

Table 8. Minor Children Present During Crime

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was a Minor Child Present During Incident&lt;sup&gt;a&lt;/sup&gt;</td>
<td>37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td>32.4 (12)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>67.6 (25)</td>
<td></td>
</tr>
<tr>
<td>Number of Minor Children Present at Incident</td>
<td>37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
<td>67.6 (25)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>13.5 (5)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>10.8 (4)</td>
<td></td>
</tr>
<tr>
<td>3-6</td>
<td></td>
<td>8.1 (3)</td>
<td></td>
</tr>
<tr>
<td>If Child Present, Involved in Incident&lt;sup&gt;b&lt;/sup&gt;</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td>83.3 (10)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>16.7 (2)</td>
<td></td>
</tr>
<tr>
<td>Ages of Minor Children Present at Incident&lt;sup&gt;c&lt;/sup&gt;</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-2</td>
<td></td>
<td>19.0 (4)</td>
<td></td>
</tr>
<tr>
<td>3-5</td>
<td></td>
<td>19.0 (4)</td>
<td></td>
</tr>
<tr>
<td>6-10</td>
<td></td>
<td>38.1 (8)</td>
<td></td>
</tr>
<tr>
<td>11-16</td>
<td></td>
<td>23.8 (5)</td>
<td></td>
</tr>
<tr>
<td>Sex of Minor Children Present at Incident</td>
<td>19</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

29
### Table 9. Collateral Victim Characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Collateral Fatalities</strong></td>
<td>37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>37</td>
<td>89.1</td>
<td>(33)</td>
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<tr>
<td>1</td>
<td>1</td>
<td>8.1</td>
<td>(3)</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>2.7</td>
<td>(1)</td>
</tr>
<tr>
<td><strong>Collateral Victim-Offender-</strong></td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Relationship</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stranger to Primary Victim and Offender</td>
<td>20.0</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>Relative of Primary Victim</td>
<td>20.0</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>Law Enforcement Officer</td>
<td>20.0</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>Other *</td>
<td>40.0</td>
<td>(2)</td>
<td></td>
</tr>
<tr>
<td><strong>Ages of Collateral Victims</strong></td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>20.0</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>20.0</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>20.0</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>20.0</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>20.0</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td><strong>Collateral Victim Cause of Death</strong></td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gunshot</td>
<td>80.0</td>
<td>(4)</td>
<td></td>
</tr>
<tr>
<td>Strangulation</td>
<td>20.0</td>
<td>(1)</td>
<td></td>
</tr>
</tbody>
</table>

*a 'Other' includes a child and a new partner of the victim.*
Table 10. Factors Significantly Related to a Perpetrator’s Likelihood of Attempting or Completing Suicide

<table>
<thead>
<tr>
<th>Perpetrator Killed or Tried to Kill Self</th>
<th>No</th>
<th>Yes</th>
<th>X²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex of Perpetrator</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>100.0 (5)</td>
<td>0.0 (0)</td>
<td>4.91ᵇ</td>
</tr>
<tr>
<td>Male</td>
<td>46.9 (15)</td>
<td>53.1 (17)</td>
<td></td>
</tr>
<tr>
<td><strong>Perpetrator Employed at DOD</strong></td>
<td></td>
<td></td>
<td>4.14ᵃ</td>
</tr>
<tr>
<td>Yes</td>
<td>37.5 (6)</td>
<td>62.5 (10)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>72.2 (13)</td>
<td>27.8 (5)</td>
<td></td>
</tr>
<tr>
<td><strong>Victim Filed for Divorce and/or Custody</strong></td>
<td></td>
<td></td>
<td>8.36**</td>
</tr>
<tr>
<td>Yes</td>
<td>0.0 (0)</td>
<td>100.0 (4)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>42.9 (6)</td>
<td>57.1 (8)</td>
<td></td>
</tr>
<tr>
<td><strong>Perpetrator has Prior Arrests for Other Assaults</strong></td>
<td></td>
<td></td>
<td>8.07**</td>
</tr>
<tr>
<td>Yes</td>
<td>75.0 (15)</td>
<td>25.0 (5)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>26.7 (4)</td>
<td>73.3 (11)</td>
<td></td>
</tr>
<tr>
<td><strong>Perpetrator has Juvenile Record</strong></td>
<td></td>
<td></td>
<td>6.50**</td>
</tr>
<tr>
<td>Yes</td>
<td>83.3 (10)</td>
<td>16.7 (2)</td>
<td></td>
</tr>
</tbody>
</table>
WHEN DOMESTIC VIOLENCE KILLS

<table>
<thead>
<tr>
<th></th>
<th>35.7 (5)</th>
<th>64.3 (9)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\* P < .05
\*\* P < .01
\*\*\* P < .001

* Of the 37 cases, 11 of the perpetrators killed themselves, and 3 attempted to kill themselves.

* Findings should be interpreted with caution due to expected cell sizes fewer than 5 in one or more cells.

Discussion

Thus far, in this report we have described an overview of the research in the area of intimate partner violence where a fatality occurred, and the nature of data collection conducted by the Denver Metro Domestic Violence Fatality Review Committee. This section is a description of what we found from careful data collection and analysis on the first 37 cases. Due to the small size of the sample, any findings and discussion should not be generalized beyond the data analyzed here. The raw numbers are therefore often included with the percentages to accurately portray the information discussed.

Case Descriptions

Table 1 is a description of the 37 cases in our sample. These involved cases occurring between 1993 and 1998 in Denver, CO, with the bulk of the cases occurring in 1996 (n=10) and 1997 (n=9). There are several other cases that occurred in Denver during this time period, but have not yet been reviewed due to criminal or civil litigation still pending. Slightly over half the cases (20) reviewed involved “only” a homicide, typically where a woman was killed by her intimate male partner. However, three out of ten of the cases involved a homicide and a suicide (n=11), and just under half the cases (48.6, n=18) involved the perpetrator killing or attempting to kill himself (all of the suicides were males). Sixteen percent of the cases involved an assault and / or an attempted homicide and a suicide. Thus, suicide plays a crucial role in the enactment of intimate partner-related killings.
Regarding the number of homicide victims, eight percent (6) of the cases involved no homicide victims, because the attempted homicide did not ultimately result in a death of the primary victim, due to timely medical intervention or some other fortunate, but unforeseen circumstance. For example, in two of these cases the perpetrator suicided in front of the victim, following an assault or threat to the victim’s safety. The perpetrator’s intention appeared to be to murder the victim, but in each case suicided only. A third committed suicide when police surrounded his house in response to a call from the local hospital that was treating the victim’s injuries.

Four-fifths of the cases reviewed in this study involved one homicide victim, and a little over ten percent (13.5%, n=4) involved more than one homicide victim (discussed further as “collateral victims”). The most frequently listed cause of death for those victims who were killed was “gunshot” (55%), followed distantly by about one-fifth of the victims’ cause of death reported as “stabbing” (19%). Sixteen percent of the homicide victims’ cause of death was beating, two cases (6%) involved strangulation, and one case (3%) the cause of death was asphyxiation. These findings are consistent with data collected on the type of weapon used. In 31 of the 37 cases a weapon was used, and in two-thirds of the cases where weapons were used the weapon was a firearm, followed by one one-quarter of the cases with a weapon reported as a knife. A bat, board, or blunt object was the weapon in only one case, and one “other weapon” included using a telephone receiver to assault the victim during the fatal incident. These data on the cause of death and weaponry used emphasize and confirm that firearms play an overwhelming role in the deaths in intimate partner-related homicides.

Table 1 also includes information on the location of these crimes and other characteristics of these cases. Almost half (49%) of the cases occurred in the joint home of the victim and offender. The next most common location was in a public space, which occurred in approximately one-fifth (22%) or eight of the cases. This included a park, a gas station, a grocery store, parking garage, street and parking lot of a child’s school. These often represented locations where the victim was followed and taken by surprise by the perpetrator, or places where they had agreed to meet, presuming some degree of safety in a public location. Sixteen percent (6) occurred in the victim’s residence and five percent (2) occurred in the offender’s residence. One case each occurred at someone else’s residence and the victim’s work site.

Other characteristics of these cases included that over half of the cases (51%) involved a witness to the offense (often a child), and in almost half of the cases where blood alcohol content (BAC) of the offender was
When Domestic Violence Kills

conducted (48%) the offender's blood alcohol content was positive. This information is typically gathered from the coroner's report as BAC's are not routinely conducted on perpetrators who are arrested. Thus, the information is mostly regarding the perpetrators who committed suicide. In some cases, the arrested perpetrator self disclosed alcohol or drug use at the time of the homicide. In over one-quarter of the cases (n=10) the victim's blood alcohol content was positive, and in the cases where the offender was tested for drugs (60% of the sample), over one-third (n=8) of these indicated a drug metabolite present. Four of the offenders had cocaine metabolite present, one, morphine and two THC and LSD metabolite. Finally, five of the thirty-six victims, almost fourteen percent, tested positive for a drug metabolite present. In each of these cases the drug metabolite was cocaine, two with THC also present.

Offender Characteristics and Criminal History

Table 2 provides a description of the offenders in these fatality cases. The offenders were overwhelmingly men (87%). They ranged in age from 17 to 79 years old with the average age around 40. A little over one-third of the offenders were White, approximately one-quarter were Hispanic, and three-tenths were African American. Asian immigrants constituted 8% (n=3) of the sample, and there was one Native American. Almost half of the sample of offenders (47%) were employed at the time of the incident, and slightly over one-third (35%) were unemployed. About 9% (n=3) were retired, 6% (n=2) were disabled and one (3%) was a student. Educational attainment was available for only 18 of the offenders. Of those where this could be determined the maximum level of education attained for half was some high school, as for 17% the maximum level was graduating from high school, and another 17% the maximum level was "some college." One individual had some postgraduate college education and two individuals had attended technical school.

The Committee was able to determine that in this sample of offenders, at least one-third (32%) had evidence of prior threats of suicide and 13% had evidence of prior suicide attempts. Again, this is bound to be a significant under-estimation, as the Committee had limited access to this information. We know that two of the perpetrators, one of whom later successfully suicided, were hospitalized for suicidal threats or behavior in the month preceding the homicide. Three others had received treatment in the past and were on psychotropic medications at the time of the homicide. This certainly underscores that suicidal ideation and practice appears to be a significant risk factor in intimate partner-related homicides.
Table 3 provides an overview on what could be found regarding the offenders' criminal history. Again, these percents likely under-represent these offenders' prior criminal history to some degree. At any rate, a significant number of these individuals have a noteworthy criminal history. Over half (54%) of the offenders had prior arrests for non-domestic assaults, and for over one-fifth (21%) there was evidence of domestic violence in previous relationships. About one-third (34%, n=12) of the sample had a record for juvenile delinquency, almost half (49%) had a prior DUI or drug possession arrest, and one-fifth (22%) had received substance abuse treatment. Two-fifths (43%, n=16) of the sample had prior domestic violence arrests, and one-fifth (21%, n=8) received domestic violence treatment. In 12 of the cases, there was documentation for a restraining order, in 5 (almost half) of these cases the offender had been arrested for violating it.

Significantly, the data collection did not identify any prior domestic violence arrests for over half (54%) of the sample. On the other hand, almost one-fifth (n=7) had 1 or 2 domestic violence arrests during the previous five years, 16% (n=6) had 3 or 4, and 8% (n=3) had between 5 and 8. The average number of arrests for domestic violence in the five years prior to the fatal incident was 1.3, but the median and modal numbers were both zero. This indicates that while a number of the fatal cases involve offenders with a serious and official record for domestic violence, a number of these cases are unknown to the police, or at least, have not resulted in any arrests for domestic violence. Even in those cases with an arrest history, almost half of those had only one prior domestic violence arrest. Regarding the number of arrests for other offenses in the five years prior to the incident studied in this project, only two-fifths (15) had none, one-quarter had between 1 and 2 arrests, and about one-sixth had 3 to 4 arrests, and another one-sixth had anywhere between 5 and 22 arrests for offenses other than domestic violence in the previous 5 years. Again, these data indicate some seriously “criminal” offenders, as well as a significant proportion who do not appear to be officially designated offenders.

**Female Offenders**

This sample includes five female offenders of intimate partner homicide, with an age range of 17 to 78. Three of the five offenders had a prior arrest history for non-domestic violence related assaults and one had prior domestic violence arrests. However, three of the five offenders had also experienced abuse at the hands of the partner they ultimately murdered, as documented in previous court records, unlike any of the female victims (or male perpetrators). The case with the elderly female offender was declined for prosecution due to significant questions about
her competency. Another female offender pleaded guilty to charges and was sentenced to probation, due in large part to the abuse and threats from her partner that was witnessed by others just hours before the fatality occurred. Due to the small size of this sample currently, we have not broken out the variables by male and female offenders. Given what the literature supports regarding gender differences in motivation and circumstances of intimate partner homicide, it will be important to see if different patterns or factors emerge, as the sample size increases.

**Victim Characteristics**

Table 4 is an overview of characteristics about the primary victim in the cases used in this study. The victims were overwhelmingly female (86%). They ranged in age from 18 to 85 years old, with about one-third under 25, one-third 26 to 40 years old, and the remaining third over 40. Similar to the offenders, the average age of the victims was about 40. The racial/ethnic make-up of the victims also corresponded with the offenders’ racial/ethnic descriptions, given that these are largely intra-racial offenses, except that while Hispanics constituted one-quarter of the offenders (24%), they made up one-sixth (16%) of the victims. In sum, almost two-fifths (38%) of the victims were White, almost one-third (32%) were African American, about one-sixth (16%) were Hispanic, about one-tenth (11%) were Asian immigrants, and one was Native American.

Regarding the victims’ employment status, almost three-fifths (57%) were employed, one-quarter (25%) were unemployed, about one-tenth (11%) were retired, one victim (4%) was disabled and another was a student. Out of the seven unemployed victims, about two-fifths (43%) received public assistance, over one-quarter (29%) relied on the perpetrator for support, and one received assistance from family and friends. Information on the victims’ education was only available in 14 of the cases, but their educational attainment appeared to be similar to the offenders, with slightly less (43%) of the victims than offenders (50%) having only some high school. About one-fifth (21%) of the victims’ highest level of education was graduating from high school and another one-fifth (21%) had “some college” as their highest educational attainment. One of the victims had attended technical school and one had some post graduate education. Although we could not obtain information on all of the victims regarding children from a previous relationship, and even less so for domestic violence in a previous relationship, our data indicate that slightly over half of the victims (52%) had a child from a previous relationship, and approximately one-in-five had experienced domestic violence in a previous relationship.
The Victims' and Offenders' Relationships and Domestic Violence-Related Characteristics

To date, most of the publication on intimate partner homicide focus on spousal killings. In a study defining intimate partners as current or former spouses, boyfriends and girlfriends, Rennison and Welchans (2000) found that most victims of intimate partner homicide continue to be killed by their spouses. That is, the victim-offender relationship most likely to result in intimate partner homicide is spouses. The findings in this sample concur with this. However, in 1998 spouses accounted for 53% of all intimate partner homicides, down from 75% in 1976 (Rennison and Welchans, 2000), thus emphasizing the need to examine all types of relationships involved in intimate partner homicide.

Table 5 provides an overview of the victim-offender relationship. Two-thirds (n=25) of the victims and offenders were cohabitating spouses/partners at the time of the homicide. Twenty seven percent (n=10) were former spouses/partners. One case involved a dating couple (had never cohabitated) and another one was a formerly dating couple. The length of the relationships between the victim and offender in this study ranged from 3 to 672 months, with a mean of 123 months or 10.2 years. About one-in-ten (11%) of the couples had been involved less than a year, and over half (53%) had been together over 3 years. In two-thirds of the cases (24), there were no children from the relationship, although one-in-six (17%) of the cases involved one to two children, and an additional one-in-six (17%) involved 3 or more children. In the cases where women were victims, 10 percent (n=3) of the women were pregnant at the time of the homicide. In one of the cases it was the victim's first pregnancy, for the others it was not. One of the unborn children survived after being delivered by Cesarean section at the time of the homicide.

Data were also collected regarding the presence and nature of domestic violence in the relationship prior to the incident, which resulted in a fatality (see Table 6). Again, this information is likely to underestimate the presence and severity, as it was most often compiled from prior police reports, or if a family member or friend interviewed during the investigation disclosed knowledge of prior abuse. There was evidence in over half the cases of two different forms of abuse: verbal harassment and pushing, grabbing, shoving or slapping. In about two-fifths of the cases there was evidence of three types of behaviors related to domestic violence: (1) stalking (tracking and following), (2) threats to kill the victim, and (3) alcohol abuse by the perpetrator. About one-third of the cases had evidence of two other forms of violence: isolating the victim and punching, kicking, or biting the victim. One-quarter of the incidents
involved evidence of property destruction or throwing things prior to the incident that resulted in a death. About one-fifth of the cases involved evidence of each of the following forms of previous abuse related to intimate partner violence: (1) forced sex or obsessive sexual behaviors, (2) drug abuse by the perpetrator, (3) threats to use a weapon on the victim, and (4) other forms of abuse not listed in the Fatality Review Committee's codebook (i.e. abuse to the children, setting victim's hair on fire, restricting food).

Almost one-fifth (19%) of the cases had some documentation of medical treatment for the victim due to domestic violence prior to the incident resulting in a fatality (Table 6). Approximately one-tenth (11%) of the cases involved a victim who had filed for a permanent or temporary restraining order against the offender. In many cases, there was some documentation of disclosure to any one of the possible people or agencies, listed in Table 6, regarding prior domestic violence in this relationship. The most common disclosure of domestic violence was to a family member (51% of the cases), followed by reports to the police (40%), friends or co-workers (30%), a medical care-provider (24%), and a neighbor (22%). Less frequent disclosures were to civil courts (14%), a shelter or domestic violence program (11%), social services (11%), and an attorney or legal services (11%). Only one of the cases involved disclosure to clergy (3% of total cases), although the Committee had little access to this information. Again, these numbers will be an underestimate, as they only reflect those instances where there was some documentation of disclosure.

Taken together, these findings on the pre-existing documentation and/or knowledge of domestic violence prior to the incident that resulted in a fatality suggest that often there are many indicators to many persons and agencies that this is an “at risk” couple. 68% of the victims had made some form of disclosure about the abuse they were experiencing before the fatal incident. However, the data also indicate that domestic violence might be very well hidden in terms of both evidential documentation and who may know about it via hearsay, victims' reports, or witnessing the violence. While it appears that family, friends, co-workers and neighbors are likely to be aware of abuse, they are often the least equipped to provide intervention and assistance. In several cases reviewed, it appeared that friends and family were a vital part of the victim's support system and attempts to seek help; offering information and advice about restraining orders and seeking shelter. In two of the cases where the victim survived, friends seemed to play a critical role in preventing her contact with the perpetrator. It is noteworthy, that one-quarter (24%) of the victims reported that they were domestic violence
WHEN DOMESTIC VIOLENCE KILLS

victims to medical care-givers, and one-fifth of the victims had received medical treatment due to domestic violence prior to the fatal incident.

A significant amount of existing literature addresses the risk for increased violence, including fatal violence, involved with an intimate partner's decision to leave a relationship (e.g., Mahoney; Campbell). Table 7 provides an overview of data collected on variables indicative of victims' attempts to leave or end the relationships. Over one-third (35%) of the couples were separated at the time of the fatal incident. Of those cases where the victim and offender were separated, eight of the thirteen couples (62%) had been separated 4 or fewer weeks. Five (38%) of the couples were separated 16 or more weeks, with the remaining couple (3%) separated 5 weeks. However, there were an additional seven cases (19%) where separation appeared to be imminent. This included situations where there had been some discussion and planning regarding a separation that others were aware of, or other actions taken toward separating. In one case, the victim had given the perpetrator two weeks to move out of their home. The homicide occurred the evening before the two-week deadline, after he brought home the weapon with which he told her he would kill her with that day. She left the house out of fear, but returned after he had gone to bed, assuming she would be safe for the night. Another case involved a victim who was making plans to purchase a house in another state. She was murdered hours after being contacted by a realtor, informing her that she had secured a new house for her. While these plans had not been kept secret from the batterer, one has to question the role that her plans coming to fruition may have played in the timing of his actions.

In the 23 cases where it was possible to determine whether there had been separations prior to the time when the fatal incident occurred, over four-fifths (83%) of the cases involved a history of separation. In these cases, the number of previous separations identified ranged from 1 to 5 times.

These findings, while preliminary, certainly underscore the need to carefully assess risk in cases where separation has recently occurred or when the victim is making plans to leave. This sample reiterates the danger during the first four weeks, but also demonstrates there is not a "safety zone" with extended separation. Of the five couples separated 16 weeks or longer, two were separated over one year. Perhaps also of some note, four of these five cases resulted in a murder-suicide of the victim and perpetrator.

Data on the possible indicators of victims' attempts to leave offenders were difficult to collect. However, where the Committee could find these
data, there was indication of recent (within the prior month) changes in
the victims' and offenders' relationships in over four-fifths (83%) of the
cases, and evidence that almost half (46%) of the victims had moved out
of a joint residence in the year previous to the fatal incident, and over
one-third (36%) of the cases involved a victim asking the offender to
move out. Over one-quarter (27%) of the cases involved a change in the
offender's residence in the year prior to the fatality, and one-third (33%)
of the cases involved a change in the victim's residence in the prior year.

Given the "sketchiness" of the data on indications of victims' attempts to
end or leave the relationship, it is useful to report the number of cases
where various behaviors were confirmed, with the understanding that if
anything, these data under-record these victims' attempts. The most
commonly reported indication (n=18) was an account by the victim of a
desire to leave, followed by victims' telling the offender they wanted to
end the relationship (n=14). In ten cases the victim had told someone
other than the offender that she/he intended to leave the relationship.
Seven of the cases included a victim initiating legal action of some kind
(see Table 7).

Another type of data difficult to find and verify involved changes in the
offenders' lives prior to the fatal incident. However, where this could be
verified, it appeared that in over half the cases some type of change had
occurred in the offenders' life in the month prior to the fatal incident (see
Table 7). This was most commonly reported as a change in the
perpetrator's finances or employment (n=7), followed closely by a change
in the perpetrator's mental health (n=6), as indicated by the psychiatric
hospitalization of three, and an attempt to get two others into treatment
by a concerned relative. Three cases involved a verified change in the
perpetrator's physical health prior to the fatal incident, and another
three cases involved some other type of loss the perpetrator experienced
(e.g., the death of a parent).

Three of the cases reviewed involved elderly couples, and seemed to
present unique dynamics associated with their age. Two of the three
cases were murder/suicide; the remaining case was declined for
prosecution due to the perpetrator's incompetence. A history of
domestic violence was identified in one of these cases; verbal abuse, very
controlling behavior, pushing and slapping had occurred during the
course of their 52-year relationship. However, no indication of past
abuse was identified in the other two cases. All three of the perpetrators
had significant health problems at the time of the fatality; one had been
diagnosed with a terminal illness and another one with dementia. Two
of the three victims were also diagnosed with dementia. Two of the
perpetrators had clearly expressed fears about their future, deteriorating
health, a fear of running out of money and an inability to care for themselves and their spouse – financially or physically.

**Minor Children Present During the Fatal Incident**

An area highly under-studied in the emerging research on intimate partner fatalities involves the presence of minor children (not to be confused with “grown” children) at the time of the fatal incident. Table 8 indicates that *minor children were present in almost one-third (32%) of the fatal incidents*. Five of the incidents (13%) had one minor present, four (11%) had 2 children present, and three incidents (8%) had three to six children present. Of these 12 cases where a child was present, in ten of them the child was somehow involved in the incident. In some instances this was an assault on the child as well as the mother, in others it was instructing the child to do, or not do something, such as the ten year old who was told by the perpetrator “Don’t come out of your room no matter what you hear”. In two cases, a child called the police and in another, an eight year old tried in vain to treat her mother’s wounds with Band-aids.

Often, the children appeared to be as much at risk as the adult victim, as evidenced by the two children murdered in this sample. One, discussed below as a ‘collateral’ victim, was killed during the incident along with her mother, apparently motivated by the perpetrator’s fear of leaving the child as a witness. The other child appeared to be killed as a “proxy” victim when the perpetrator did not have access to the adult victim. Although divorced, the father continued to try to discuss reconciliation with the mother. When the child was visiting the father, he continually called the ex-wife. During one of these telephone calls, he walked into the child’s bedroom, fatally shot the child while he slept, returned to the phone to inform the mother what he had just done, and then proceeded to suicide with her still on the line. These murders were clearly domestic violence motivated and it became apparent that the data collection tool as it stands does not accurately capture the dynamic in these types of cases. Identifying these deaths as ‘collateral’ does not reflect the intentional execution of these children, or help us understand when a child may be at most risk from a domestic violence perpetrator.

The ages of the minor children ranged from eight months to 16 years old, with over one third (38%) aged 6 to 10 years old. Notably, girls (68%) were twice as likely as boys (32%) to be present at the time of the incident. An area of interest was determining if, or to what extent the children received intervention following the homicide. Keeping in mind
the small size of this sample, in eight of the eleven cases, or almost three-quarters (73%) of the children present during the incident received some type of intervention as a result of the incident. Most often, this was crisis intervention and emergency services due to the homicide, typically by social services or victim assistance with the police department. The Committee was sometimes able to identify if children received counseling immediately afterwards, however it was often unknown how long those services were received, or what specific expertise the providers had in domestic violence and/or treating child homicide survivors. If these services were provided, was highly dependent on the new caregiver's recognition of the trauma suffered by the child and their financial and emotional ability to follow through on ensuring sufficient counseling was available.

It cannot be overstated how profoundly and tragically children are affected by these crimes, whether they were present at the time of the homicide or not. Well noted by advocates in the field, children are often acutely aware of the abuse and associated risks, despite an adult's perception of shielding the child from direct exposure to the abuse. This was clearly illustrated in two of the cases reviewed where the children were not present at the time of the fatality. When told of their mother's death, even prior to knowing the circumstances in which she died, each child spontaneously asked, "Which gun did my father use?"

**Collateral Victim Characteristics**

The Committee also collected data on what we refer to as "collateral victims," or those victims murdered that were not a current or former intimate partner of the offender, but their deaths occurred in the context of, or as a result of abuse between current or former intimate partners (see Table 9). In this study, slightly over ten percent (11.1%) of the cases involved a collateral fatality. Three of the cases in this study involved one collateral death and one case involved two collateral deaths. The ages of the 5 collateral victims in this study ranged in age from 4 to 37. One case involved a child of the victim and in another the victim was a police officer responding to the scene. The other victims included a new partner, killed by the former partner, and a co-worker of the victim. Four of the five collateral victims died due to gunshot wounds and one died from strangulation. These findings emphasize that intimate partner abuse is not only potentially fatal to the current or former intimate couple, but to family members, police who respond, and complete strangers who may intervene to help domestic violence victims.


**Case Dispositions**

18 of the offenders suicided at the time of the incident; the remaining 19 were arrested. 16 (89% of those arrested) offenders were initially charged with First Degree Murder, 2 (11%) of them were charged with Second Degree Murder and one with Conspiracy to Commit Murder. Two cases, both with female offenders, did not proceed further than the initial arrest - one due to a determination of self-defense, the other due to questions regarding the offender’s competency. The remaining 16 cases proceeded through the criminal justice system.

Six of the cases resulted in a conviction for First Degree Murder (37.5%), seven offenders (44%) were convicted of Second Degree Murder, one conviction for Manslaughter and two of Conspiracy to Commit Murder. Twelve of the cases (75%) went to trial, five accepted a plea bargain; including one defendant who pleaded to 2 counts of First Degree Murder instead of having the death penalty as a sentencing option at trial. Sentencing ranged from 3 years probation in one case, to life in all instances of First Degree Murder. Of those offenders convicted of Second Degree Murder, sentencing ranged from 3 to 48 years. One of the offenders convicted of Conspiracy to Commit Murder received a 98-year sentence. One perpetrator suicided in jail while awaiting sentencing, following his conviction of First Degree Murder.

**Beyond Frequencies: The Interaction Between Variables**

Given the small size (n=37) of cases in the current sample, it is difficult to conduct meaningful bivariate or multivariate analyses in order to determine whether various characteristics of the case are related. However, we did make an attempt to look for and report some of these patterns. First, we were interested in determining how the criminal histories of the perpetrators “played out.” Notably, of those offenders in this sample who had a criminal history, only one of them “only” had a domestic violence criminal history. Two of the offenders had an assault other than domestic violence as their “only” pre-existing criminal history, and another two of the offenders had a “driving under the influence” as their only previous criminal history record. However, 18 of the offenders in this sample had some combination of arrests for these three variables (domestic violence, assault other than domestic violence, and DUI).

A characteristic in these fatalities that appeared to be uniquely related to some of the other characteristics of these fatality cases was whether the offender, in addition to killing or attempting to kill someone, also killed or attempted to kill himself. Thus, we conducted analysis on how the perpetrators’ suicide attempts (successful and otherwise) were related to...
other case characteristics. The cross-tabulations indicated that suicide attempts were unrelated to the offenders' age, use of alcohol or drugs at the time of the incident, the number of children the couple had who were not both of the members of the couple's offspring, and the length of the relationship between the victim and the offender. However, Table 10 reports indicating characteristics significantly related to the offenders' attempts to suicide in addition to cause a fatality. Notably, none of those attempting suicide were female. Second, employed perpetrators were more than twice as likely as unemployed perpetrators to try to kill themselves (χ²=4.14, p≤.05). This is consistent with reports by Sherman (1992) that that arrest is more likely to be effective with more "socially bonded" individuals. That is, that an arrest is more costly to one's status if one is employed and wealthy. Following from this concept, a person who has committed an attempted or completed homicide who has no or a limited criminal history or who is better employed, may be more likely to believe "life isn't worth living" than her or his counterpart. Consistent with this socially bonded concept, perpetrators without arrests for other assaults were three times as likely (73%) to try to suicide as those with arrests for prior assaults (χ²=8.07, p≤.01), and perpetrators without a juvenile offense record were (64%) about three times as likely as those with a juvenile record (17%) to attempt suicide (χ²=6.50, p≤.01). Another important finding was that in all of the cases (n=4) where the victim had filed for divorce and/or custody, the perpetrator attempted or completed suicide, where in the remaining cases, fewer than three-fifths (57%) of the perpetrators had done so (χ²=8.36, p≤.01).
Risk Assessment

"The conventional wisdom with respect to the prediction of violence is that we cannot do it. This is, of course, utter nonsense. The urban dweller who fails to cross the street after noticing a nasty-looking assemblage of young toughs on the sidewalk ahead is either very brave or very foolish. The circumspect street-crosser, on the other hand, wisely has made a prediction that violence MAY occur and has taken steps to avoid it. Not only CAN we predict violence, virtually all of us DO engage in the prediction of violence. Depending upon our positions in society, the law may even require us to do so.

Out of the conventional wisdom that we cannot predict violence has arisen the ethical stricture that we may not predict violence. This too is utter nonsense.... It is in the consequences of prediction, not the fact of it, that ethical problems are raised."

Gottfredson & Gottfredson, 1988

Of particular importance to a study of intimate partner homicide is an exploration of risk factors preceding lethal violence. Since the Committee formed in 1996, it has closely followed the work being done on a local and national level as we have developed our own thinking about risk assessment.

As stated previously, the risks of victimization for men and women appear to be different. Studies have consistently reported that women are at the greatest risk for being killed by their intimate partner when they attempt to leave or end the relationship (Browne, 1997; Campbell, 1992; Cazenave and Zahn, 1992; McFarlane et al., 1999; Morton, Runyam, Moracco, and Butts, 1998; Wilson and Daly, 1993). Wilson and Daly (1993) found that the risk is the greatest within the first two months after leaving. This does not appear to be a factor in female killings of male partners (Wilson and Daly, 1993).
McFarlane and colleagues (1999) found that experiencing stalking by their male intimate partner prior to their murder appears to be a risk factor for women. In their study, 76 percent of the actual femicides and 85 percent of the attempted femicides had involved stalking within the 12 months prior to their actual or attempted murder (McFarlane et al., 1999). When males killed their female intimate partners, other studies cited the following risk factors: the presence of weapons in the home, the use of weapons in previous incidents, threats with weapons, threats by the male to kill, and life threatening injury in previous incidents (Campbell, 1992; Sonkin, Martin; and Walker, 1985).

Browne (1997) compared intimate partners who kill to those who do not. Men who kill were more likely to abuse alcohol or drugs and were more likely to have threatened to kill their female intimate partners before they actually killed them (Browne, 1997). Browne (1987) cited the following as risk factors for female partners killing male intimate partners: frequency of violent incidents, severity of injuries, men's threats to kill, women's threats of suicide, man's drug use, man's frequency of intoxication, and forced sexual acts. Moreover, Browne's (1997) comparison of battered women who have not killed their intimate partners to battered women who killed intimate partners, reported that the latter have experienced more abuse more frequently, experienced more injuries, and experienced a higher frequency of rape.

While escalation of violence is frequently mentioned as a risk factor, an analysis of the data collected by the Committee did not reveal any evidence of this. This may be in part due to difficulty finding information to define this type of variable. Detailed information about the nature or severity of violence is often absent, and in those few cases where a series of arrests prior to the fatality was present, it is difficult to determine if this is due to the violence escalating, or the victim's increased help-seeking behavior and involving the criminal justice system, or other undetermined factors.

Other research the Committee considered include, Reid Meloy and Robert Hare's research regarding violence assessment, and the Spousal Abuse Risk Assessment (S.A.R.A.). While Meloy's and Hare's work is not specific to domestic violence, it offers some important insights into the obsessive traits or "acuity" often observed in domestic violence cases resulting in homicide or suicide. Unfortunately, research to date has not described factors of significant discriminate power. On-going work in refining risk factors in intimate partner homicide will lead to greatly improved intervention strategies to prevent intimate partner homicide.
A primary goal of the Committee is to see if an analysis of the data can shed any additional light on risk factors for those cases most likely to result in fatality. While many risk factors have been identified based on clinical experience, we are interested to see if the data support those already recognized, or can help better ascertain new, more powerful factors indicative of lethality. The goal of the Committee has included the development of a risk assessment tool, supported by the data, and that could be used in a broad range of settings.

Throughout this process has been a desire to make clear distinctions between those women who were killed, and those battered, but not killed. However, a clear delineation cannot be made. It is important to recognize the vast amount of work that has occurred and the increased resources developed within the battered women’s movement over that past twenty years. There is clearly no way to determine which women would have been killed, had timely intervention not occurred, had they been accessible to the batterer, had she not had an effective safety plan in place. It can be argued that the interventions developed over the past two decades are working, as evidenced by the overall decrease in the number of women (and men) being killed by their intimate partner. However, much work remains to be done.

The issue of risk assessment in this field has generated a great deal of discussion and controversy. The wisdom of doing risk assessment in domestic violence cases is debated on ethical grounds as well as issues of practicality. Yet, for therapists and advocates who work with victims or batterers, the reality is, risk assessment is exactly what occurs, if competent work is done with these clients. It would be naïve, unethical and irresponsible to work with this population and not recognize that each and every case that comes before the clinician presents some level of danger. The assessment may often occur on an informal, perhaps intuitive level, based on the clinician’s experience and understanding of the dynamics of domestic violence. However, this process may be flawed or limited depending on the clinician’s level of experience and exposure to the issue. Assessment may be severely hampered if the client(s) fail to identify abuse or violence as an issue, or minimize or deny its presence, as most cases, male or female, victim or perpetrator, will do. A primary goal of the Committee has been to take the experienced clinician’s assessment skills, and combine and compare them to a statistical analysis of the cases where fatality did indeed occur. Would this analysis uncover different factors, or would the process confirm those factors already assessed by the clinician? Could the review process help professionals in this field better identify and articulate those factors and circumstances that cause them greater concern in a given case?
As stated earlier, another key goal is to develop a risk assessment ‘tool’ or model that can be used in a broad range of settings. Victims and perpetrators may never seek formal intervention, but family, friends, co-worker or neighbors may see warning signs, and not know how to assess or respond to their concerns. The majority of batterers never make it into treatment unless court ordered; which means they typically will have contact with a multitude of other professionals before reaching the clinician: police, prosecutors, probation, medical or clergy, to name only a few. Women who are in abusive relationships may use a spectrum of services with or without identifying the violence in their lives. There are many mental health professionals who do not specialize in domestic violence and need additional resources when they have concerns about abuse as an issue for a client. Each of these individuals could benefit from a screening tool to assess risk of serious harm to help guide intervention strategy and safety planning.

**Benefits and Limitations of Risk Assessment**

*Prediction* is simply the use of items of information, alone or in combination, to make a guess about the probable future occurrence of some event or behavior (known as the criterion).*

Gottfredson and Gottfredson, 1988

Clearly, we have a very long way to go before we can say – if ever – that we can predict cases likely to end in fatality. Indeed, that may not be a reasonable or desired goal in conducting risk assessment. Risk assessment can be a useful frame of reference if one is clear on **what type of risk you are assessing for**, and **what change in intervention will occur** as a result of the assessment. Some risk assessment models look at risk of re-offense, some look at risk of failing probation or treatment programs. These generally help determine what level of supervision is required. A fundamental premise for the Committee is that risk assessment should never be utilized to screen people out of services, but can be useful in determining when enhanced or expedited intervention is required. While there has been a recent trend toward trying to categorize batterers as “low risk” or “high risk”, one must start with an assumption that the risk of homicide is present in every situation where there is a history of abuse. This should also include cases where verbal abuse, obsessive jealousy, stalking and other controlling behavior are identified. The review process identified several cases where the first apparent act of physical violence was the homicide. A primary motivation in the Committee’s desire to address risk assessment has been the need to ensure that relevant questions are being asked of victims and perpetrators at every point of contact.
Another benefit to a risk assessment model is the development of a shared language among service providers, enhancing communication and coordinating intervention. Due to training and experience, there are often differences in language used by police, domestic violence advocates, therapists, probation staff, prosecutors and judges, in describing a particular case or set of facts. There is also great benefit to understanding each other's roles, and the confidentiality and legal standards that each profession must adhere to. While the advocate or therapist may be concerned about a perpetrator's pattern of obsessive behavior, objectification of partner and sense of entitlement, as risk factors, these terms will not be the most appropriate to communicate those concerns to the criminal justice system. The advocate and therapist need to know how to present those issues in a way that the investigating detective can determine if criminal violations have occurred, what evidence of that risk a prosecutor can use and a jury can evaluate, and how probation can present information to the judge in determining appropriate containment measures.

Of equal importance is the benefit to the victim in discussing the issues identified in the risk assessment regardless of the actual determination of risk. Even if the current risk is low, the victim is better informed about potential warning signs to be aware of should they begin to occur. With this information, she can craft an appropriate safety plan and may better protect her safety or seek out resources at an earlier stage.

**Risk Assessment Process**

Two main issues continued to surface as the Committee has reviewed cases and worked toward developing a risk assessment model. **One has been the challenge in timely access to information.** Often, only after the fatality is relevant information pieced together. Albert Petrosky's criminal history was not known at the time the restraining order was issued. The hospital personnel who treated a batterer following a suicide attempt (and who less than a month later successfully suicided) did not know he was on probation for domestic violence, with new warrants pending for his arrest. This information often makes a critical difference in the assessment of risk. It is rare that one intervener at one point in time will be able to gather all the information necessary to contribute to an accurate assessment. What is more common is that different interveners will have different pieces of information; thus an accurate assessment cannot be made. For a variety of reasons the batterer and the victim may not disclose all the information, or minimization by either or both parties (if she is still invested in the relationship, or in fear of retaliation from him) may color the information disclosed to the person doing the assessment. Parties who have contact with only the batterer, or only the victim will have critically limited information.
The victim is not likely to have accurate information about the batterer's past. There may not be a way to access all the information we'd like, but a risk assessment model can increase the likelihood that the right questions are asked, and that there is an expectation that coordination with other agencies and service providers will occur. While a fatality review Committee can't solve all the problems it's a good start.

The second issue reinforced is that risk assessment is not a static, single event; it must be seen as an on-going process and done at every point of contact with the victim and/or batterer. By continuing to gather and reevaluate information, the intervener is likely to gain additional information. Their lives are not static, and as discussed below, changes in situational factors will greatly influence the assessed risk of lethality. Previous research and risk assessment tools often overlook the interaction of variables that are likely to change over time.

While the current sample is notably small, a review of the data has reinforced several factors, which have been incorporated in the development of the following risk assessment tool. Separation, or the perception that a separation is imminent, is indeed a significant factor and presents a critical time. This is more evident when there has been a history of separation in the relationship. The most critical time appears to be during the first four weeks. Yet, in five of the cases reviewed, the fatality occurred significantly after the initial separation (over a year in two of the cases), but in each case there appeared to be some change in circumstance that indicated to the perpetrator the breakup was indeed, final. It is of interest to note that all of the perpetrators who were divorced successfully suicided, perhaps reinforcing the finding that married women may be at more risk of murder / suicide. Several of the couples had never co-habitated, making the issue of separation more obscure. However, a change in circumstance, indicating some perceived loss of his control over her behavior, still seemed to be present.

Other factors that at this preliminary stage also appear to be significant include the violation of protective orders and / or other indications of non-compliance with probation conditions and other court orders. The presence of a restraining order itself does not appear significant, as only 12 (32%) of the cases had one in effect, but of those that did, 5 of the perpetrators had arrests for violating them.

Criminal history does not predict lethality. A considerable percentage of offenders had no criminal history, while others had an arrest history the size of a phone book. Those with an arrest history committed a spectrum of offenses, but especially auto-related, DUI offenses and non-domestic assaults. The challenge continues to be identifying those variables that can
make useful distinctions and are not so overly broad as to be meaningless. As stated by Gottfredson & Gottfredson (1988):

"The commonsense predictors for domestic violence homicide are particularly difficult to demonstrate. Specifically, possession of guns, previous severe violence, previous police contact and heavy drug use fail to statistically predict domestic homicide. Because these characteristics are so widespread in our society, they grossly over-predict domestic violence."

**Risk Assessment Model**

In thinking about risk assessment, the following model divides the factors into three strategies of assessment. As applied by Gary Gibbens in domestic violence risk assessment, this framework addresses historical, or psychosocial factors, situational and motivational factors. The first category simply assesses the individual’s Psychosocial History and those variables that are indicative of violent or abusive behavior. Current Situational Factors assess the present circumstances and stresses. Motivational Dynamics address the underlying dynamics that appear to drive the behavior; the acute symptoms; what is happening in the moment. Some factors will be static (i.e. historical), others will be very volatile. This allows one to not only assess the individual, and variables that may make him (or her) more prone to violence, but also evaluate the context in which the person is currently functioning. Thus, the more Motivational Dynamics are present, the more risk to the victim will need to be scrutinized and acted upon.

We intuitively know that current stressors combined with motivational triggers will escalate a situation, but risk assessment tools often do not adequately capture this dynamic. Therefore, the tool is an effort to capture that **timeframe** within which the particular individual may be more likely to commit lethal violence, and require more timely and intensive intervention. The more effectively we can predict the lethality of the situation the better our efforts to keep the victim out of harm’s way or help the would-be perpetrator to control his lethal impulses and help to identify more constructive solutions to the conflict he faces.

The tool is meant to be cumulative; starting with information that will be accessible to most first responders, if the questions are asked. Each tier builds upon information from the previous one. The second and third tiers are applicable to interveners with more assessment and interviewing skills, and who are likely to have more time with either the victim or batterer. This may include staff at a battered women’s program, probation intake personnel, investigating detectives or mental health professionals. The third
tier is targeted to the batterer treatment and/or therapeutic community who is likely to have on-going contact with a perpetrator (and some expertise in domestic violence).

**Tier I**
These factors should be included in an assessment whenever there is concern about abusive or violent behavior. Tier 1 includes basic information that should be ascertainable to anyone, if the question is asked. In particular, Tier 1 is applicable for law enforcement, paramedics, mental health or health care providers in crisis response settings and clergy. It can also be utilized by concerned family members, friends, or co-workers.

**Psychosocial / Violence History**
- Past **history of abuse** in the relationship; reported or unreported.
- Past **arrest(s)** for domestic violence crimes.

**Current Situational Factors**
- Presence of, or access to a **firearm** or other lethal weapon(s)
- Recent (within the past month) or imminent **separation**
- Current **threats** to harm or kill victim, especially if specific to method or circumstance
- Current **threats of suicide** by perpetrator
- **Pending criminal case(s)**, warrants or revocations
- Changes or **instability** in perpetrator's housing, employment or financial status in the past month
- Perpetrator **currently** under the influence of **alcohol or drugs**
- **Victim expresses fear of being killed** by the perpetrator
- **Victim is pregnant**
- Perpetrator **combative or resisting arrest** during current incident
Motivational Dynamics / Triggers

- Escalation of obsession with victim, including jealousy, controlling or stalking behavior

Tier II
In addition to those factors listed above, the following should be evaluated by interveners likely to have more time with either the victim or perpetrator, and access to the additional information. This category includes probation officers, detectives, shelter staff, system and community based victim advocates, prosecutors, primary care physicians, social service caseworkers, domestic relations attorneys, school counselors and mental health counselors.

Psychosocial / Violence History

- Prior arrest for DUI and/or other non-domestic violence assault, harassment or threats
- Previous use of, or threats with weapons during assault
- History of substance abuse, particularly stimulants, as well as alcohol
- Incident(s) of nonconsensual sex, including marital rape
- ‘Parasitic’ life style (feels entitled to live off others, no motivation to support self or contribute to other’s welfare)

Current Situational Factors

- Protracted divorce, custody or property disputes
- Changes in perpetrator’s sleep patterns
- Victim feels hopeless, powerless about changing or escaping relationship
- Perpetrator lacks positive support system and coping skills; isolated
- Recent and dramatic change in perpetrator’s mood (depression or anxiety)
- Psychiatric hospitalization of perpetrator within the past month
Motivational Dynamics / Triggers

- Blames victim for violence; perpetrator describes self as victim
- Obsessive sexual jealousy; believes victim is involved with others
- Increased or recent depression in perpetrator; arising out of a perceived loss of hope, helplessness
- Restraining Order violations

Tier III
In addition to those factors in Tier I and II, the following should be assessed when the intervener is likely to have on-going contact with the victim or perpetrator, and has skill in diagnosing and assessment. This includes Victim or perpetrator treatment providers, psychiatrists, and any mental health professional.

Psychosocial / Violence History

- Abandoned / neglected / abused as a child
- Witnessed domestic violence as a child
- History of severe depression (including family history of depression)
- Dependant relationship with one or both parents
- History of diagnosed mood disorder / bi-polar disorder
- Diagnosis of severe personality disorder
- Evidence of primitive problem solving (fire setting, cruelty to animals, 'strategic' encopresis)
- History of psychiatric treatment / past involuntary hospitalization(s)
- Extreme and unreasonable sense of ownership or entitlement to victim

Current Situational Factors
WHEN DOMESTIC VIOLENCE KILLS

- Non-compliance with court orders; reported or unreported to authorities (probation revocations, violation of restraining, divorce, visitation or custody provisions)
- Recent or imminent change in status of relationship; increased independence of, or perceived loss of control over victim
- Perpetrator stops taking prescribed medications

Motivational Dynamics / Triggers

- Acute paranoid ideation or delusional system
- Obsession or identification with weapons and killing fantasies (refer to Reid Meloy’s Weapons History Assessment)
- Acute narcissistic rage*
- Current acute manic state*

**Symptoms of Narcissistic Personality Disorder** include: (Refer to DSM IV for a complete discussion of symptoms and identification)

- Reacts to criticism with feelings of rage, shame or humiliation, even if not overtly expressed.
- Is interpersonally exploitive: takes advantage of others to own ends.
- Lack of empathy: inability to recognize and experience how others feel.

**Symptoms of Acute Manic Stage** may include: (Refer to DSM IV for complete discussion of identification and symptoms)

- Inflated self-esteem or grandiosity.
- Decreased need for sleep.
- Flight of ideas; racing thoughts; pressured speech; distractibility.
- Increase in goal-directed activity or psychomotor activity.
Principles in Risk Assessment

There are several key points to remember in conducting risk assessment.

Everyone has a role to play. Too often, the concept or task of risk assessment is delegated to one or perhaps two individuals – the probation department, the batterer treatment provider, the victim advocate. There needs to be increased awareness that everyone who has contact with a batterer, victim or child living in a home where battering occurs, has a role to play in assessing risk and offering options for safety. This may start with an extended family member, co-worker or employer, and extend to the first responding police officer, victim advocate, prosecutor, judge, etc.

Risk assessment is not a static event. Assessment of risk will change over time and as circumstances change in the victim and perpetrator’s life. Therefore it is critical that risk assessment and safety planning be perceived as an on-going process which should be reviewed each time there is contact with the victim or perpetrator.

No one individual or agency will have all the relevant information. Risk assessment is only as good as the information you have, and collateral sources of information should always be sought out. Therefore it is critical to have systems in place that help determine who is most likely to have information, who needs the information you have and how to pass it along in a timely way. Risk assessment must be seen as a collaborative process.

Trust your gut. Risk assessment is still a tenuous process. No tool should be a replacement for what our intuition or clinical judgment tells us, or what the victim tells us about the danger she perceives.

Response to Heightened Risk

Perhaps most critical to the process, is determining an appropriate response in situations where there is heightened concern. Any response strategies should include the following:

- Family members, friends, co-workers or paraprofessional interveners should be aware of the domestic violence resources in their community. If the first resource they contact dismisses or minimizes their concerns, keep calling until someone is willing to listen and assist in responding to the concerns.

- Work with the victim (or ensure she has appropriate resources to work with) to maximize her safety. Be sure she knows of the current
concerns and why. Coordinate and ensure simultaneous work is being done with the perpetrator to develop a containment strategy, or perpetrator self-control plan.

- Determine who else is involved with the perpetrator and/or the victim, and who else has information you need, or needs the information you have. Consider both formal and informal sources. Whenever possible, get together and strategize intervention collaboratively.

- Determine if further legal interventions can occur: new criminal charges, mental health commitment, probation revoked or new conditions imposed. Work with the appropriate agencies and let them know of the immediacy of your concerns. Find out if and how the standard procedures can be expedited due to elevated risk.

- If the perpetrator does not have access to the victim, are other individuals at risk? Be sure to consider the safety of children, parents, new partners or others (especially those the batterer may think are helping the victim) and include them in notification of your concerns and safety planning.

- Be sure all intervention occurs expeditiously! If it needs to happen today, make sure it happens today! Remember, we’ll never know if we’ve over reacted, only if we’ve under reacted.
Women who live with abuse and violence in their lives evaluate risk to their safety and develop strategies for reducing those risks on a daily basis. They may or may not do this on a conscious basis. "Safety Planning" is turning this into a conscious, pro-active process, to use the strategies and resources a battered woman has available to her, and provide her with additional information, ideas and resources. Anyone who works with victims should be familiar with how to help her identify risks relevant to her situation, and increase strategies and resources to minimize them. This needs to be done in partnership with the woman, as risks (and subsequently the safety plan) will change as circumstances change. Increasing her ability to evaluate risk to herself and her children, and her ability to modify a safety plan as necessary, may be one of the most important tools to help increase her safety from a perpetrator. A safety plan can include:

If possible, identify patterns of escalation. Help the victim identify early cues of escalation, so she can try to leave or get help before things escalate further.

Keep an extra set of car and house keys elsewhere – with a neighbor, friend or somewhere else they can be accessed in an emergency.

Keep copies of important documents: birth certificates, social security numbers, financial records, health records, etc.

Keep an extra bag of personal belongings elsewhere – overnight clothing for yourself and your children, favorite toys / blankets for kids, extra medication.

Identify two or three resources to call in an emergency: police, family, local domestic violence resources. Have the numbers available at all times.

As appropriate, teach children how to call the police and /or the other emergency resources you identify. Discuss the safety plan ahead of time, and what they should do when violence occurs.

Develop a code word or phrase to let family or friends know to call the police, if the victim is unable to during an incident.

Evaluate what safety plans need to be developed for the work environment, children's school or daycare, travel between home and work, etc. Decide who else needs to be a part of the safety plan (coworkers, supervisors, apartment security, etc) and how they can help.
What we’re talking about is increasing the statistical probability of accurately identifying those cases more likely to result in serious or lethal injury to a victim. While “prediction” may be a strong term to use at this juncture; it may not be an unreasonable goal. A reality exists that mistakes will be made in our assessment efforts. However, as pointed out by Gottfredson and Gottfredson (1988) mistakes will be made if we don’t engage in assessment and predictive efforts. Therefore, we need to utilize all tools and information available to us to find ways to most effectively assess risk to domestic violence victims.
Recommendations

While the small size of the sample does not yet lend itself to identifying any clear trends or patterns, there were several issues that surfaced repeatedly during the case reviews and Committee discussion. The following recommendations stem from those issues identified.

- **There is a critical need to improve how information is tracked throughout the criminal justice system.** Obtaining a thorough criminal history across multiple jurisdictions is frequently a challenge. In the Denver metropolitan area, there are at least three major jurisdictions that charge a large number of domestic violence crimes at the municipal level. Given the fluidity of the population, this information needs to be available to all of the jurisdictions. While prior arrest information may be available, law enforcement, prosecutors, judges and probation need **complete and timely** access to information about arrests, cases disposition and current case status.

We are aware this matter has been identified and is being discussed in other forums as well, however the Committee has identified this fragmentation of information as a significant barrier in the ability to accurately assess risk and determine the most appropriate interventions. Too often, decisions are made with incomplete information across jurisdictions, and across systems, sometimes within the same jurisdiction. If one jurisdiction is not aware that a defendant with a new arrest is on probation in another jurisdiction, or the judge in a divorce case doesn’t have knowledge that a respondent has had a new domestic violence arrest and is having probation revoked on another, these interveners are missing vital pieces of information which could influence their response. Too often, it is up to the victim to pass information along. Technological resources need to be developed (and resources committed to timely implementation) that will integrate this information and are compatible and accessible across systems.
• A secondary consequence of this fragmentation, is the difficulty in **generating accurate statistics on domestic violence arrests and homicides across the state.** Two issues seem to contribute to this. One, as mentioned, is the number of domestic violence arrests that occur at the municipal level, and are not consistently tracked or reported at the state level. Secondly, while all jurisdictions are mandated to provide statistics to the Colorado Bureau of Investigation, not all do. In 1999, CBI received documentation from 220 of the 238 reporting agencies statewide. While compiling information and statistics may not seem a priority when a law enforcement agency is struggling to respond to immediate needs, without accurate statistics, gaining a deeper understanding of the dynamics and associated risks will remain a challenge. Determining effective policy and appropriate allocation of resources will not be possible without an accurate reflection of the extent and impact of the problem.

• Related to this, there is currently no way to track homicides that occur secondary to domestic violence. Some of the homicides included by the Committee as “collateral” are included in statewide statistics, some are not. Again, it would be of benefit to develop standard definitions throughout the state, in order to begin tracking these homicides as well as intimate partners killed. If we are to develop policy and effective means of intervention, we must have an accurate picture of the toll domestic violence exacts on society as a whole.

• **There is a need to institute earlier and regular points of risk assessment within the criminal justice system.** Victim advocates within the system will make an informal assessment of risk and help the victim develop a safety plan and refer to community agencies, assuming the advocate is successful in contacting the victim. However, an assessment with the perpetrator often does not occur unless and until they are referred to probation and/or they enter domestic violence treatment. In the best-case scenario, this may be weeks after an assault. More typically, this occurs many months afterwards.

In several cases reviewed, this time was a critical period, during which there was no formal oversight in place to help contain the perpetrator, or resources to help the victim evaluate risk. In analyzing the data, there was a discrepancy in the number of offenders arrested for domestic violence, and those who received domestic violence treatment. Since this is a mandated requirement of sentencing in Colorado, the Committee was concerned this had not
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occurred, and why. A closer analysis of these cases revealed that in all situations, the fatal incident occurred before the domestic violence case in question was adjudicated. In some of the cases, the fatality occurred within days of a court date, or while probation revocation for non-compliance was pending. Currently, there are no formal systems in place to track defendants with multiple cases pending, or protocol for appropriate monitoring in such circumstances.

This demonstrates a need for earlier points of risk assessment, to help determine which cases may be prone to escalation, and developing better options for court intervention and containment while a case is pending. Options discussed by the Committee include the development of specialized pre-trial services, the ability to order forms of treatment pre-conviction, and establishing 'compliance hearings' to monitor the defendant while a case is pending.

- **There needs to be closer collaboration between the domestic violence community and the substance abuse and mental health fields.** While work with domestic violence perpetrators and victims has become an area of specialization for necessary and valid reasons, there is a need for a broad spectrum of practitioners to have a solid understanding of domestic violence dynamics and skill in screening and assessment for these issues. The review process disclosed a strong overlap between domestic violence offenders who also had an arrest and treatment history for substance abuse. Court ordered treatment for substance abuse provides a crucial opportunity to also screen and assess for domestic violence issues and determine treatment and intervention needs. Likewise, screening for emergency mental health treatment also needs to incorporate assessment of domestic violence and concurrent risk. Several cases clearly pointed to the current inadequacy of involuntary commitment laws to provide appropriate screening or intervention in the escalation patterns endemic to domestic violence. Suicidal behavior by domestic violence perpetrators appears to be a significant risk factor for domestic violence homicide, which standard assessment for suicide may not assess.

- **There is a need for closer collaboration with the medical community.** Health care providers are an important resource utilized by battered women. Yet the cases reviewed by the Committee found great inconsistency in how the medical community responded to disclosures of abuse. Colorado physicians have been clearly mandated to report cases of injury caused by domestic violence since 1996, a law that has generated a fair amount of controversy. Cases were reviewed where past injury had not been
reported, and thus no legal intervention could occur. Contact with
the medical community also provides a crucial opportunity for
intervention – the ability to provide the victim with information,
support and linkage with other resources. Mandated reporting
should not be a barrier to collaboration, but can hopefully advance
on-going dialog to gain a better understanding of how the medical
and legal communities can interface to most effectively intervene and
promote victim safety.

- One of the more distressing issues identified by the cases reviewed,
  was the degree to which children are directly impacted and at risk by
domestic violence homicide. The development and
continuation of collaborations between the domestic
violence community, child protective services, community
based services for children and schools are essential.
Creative strategies must be developed to provide earlier identification
and intervention to children who live in homes where domestic
violence is a reality. Identifying and intervening with children who
are going through a protracted divorce and have visitation with a
parent who has a history of abusive or threatening behavior (with
their spouse) is also essential. The assumption, all too often made by
the courts, that a parent who has been abusive toward a spouse, will
not be abusive to the children, must stop. A look at the statistics
clearly show children are at risk of lethal violence from domestic
violence motivations. The child deaths identified not just in this
sample, but throughout the state, demonstrate how often children
are intentionally killed as a substitute victim, as a means to punish
the surviving parent, or as an extension of the perpetrator’s sense of
ownership over his victim – adult or child.

- A related issue is the need for on-going support and
services to children who lose one or both parents to
domestic violence homicide. In some cases, the caretakers of
the surviving child(ren) seemed very aware and attentive to the
devastation and long range impact. However, the Committee was
often left with the lingering concern that the child(ren)’s needs may
not be recognized or met. Children experience and express grief and
loss differently than adults – which caretakers may or may not
realize, especially if they are dealing with their own grief reactions.
Recovery and treatment for children will also look very different, as
developmental stages impact their awareness, insight and emotions
regarding the event. While some families have the emotional and
financial resources to appropriately meet these needs (short and long
term), others do not appear to. There is a need for additional
WHEN DOMESTIC VIOLENCE KILLS

resources to meet the on-going needs of these children and their caretakers.

- **The need for community education and awareness remains paramount.** Even with missing data, it is clear that victims and perpetrators often disclose information about the abuse to others in their environment. By the time a case comes to the attention of the criminal justice system, many others are often aware, but may not have the tools or information about how to help intervene. Community education needs to continue to generate awareness, especially among the 'natural' support systems that a victim or perpetrator may be likely to seek out at an earlier stage – family members, friends, neighbor, clergy, co-workers.

Community education also needs to be targeted to employment settings. Co-workers and supervisors may be in a key position to provide assistance and intervention to a victim or a perpetrator. Victims may conceal information about abuse due to fear of losing their job or being harshly judged by a supervisor. However, the worksite may be the one place the batterer knows to find his victim – putting her (and possibly others) at risk. An informed supervisor will not only be able to offer a victim appropriate support and information, but may avoid a crisis occurring at that location. The employee who receives multiple phone calls from a significant other, despite requests not to call, becomes anxious at the prospect of leaving work late, "reports in" to significant other many times throughout the day, etc – should all be warning signs an employer heeds. Employers need training and assistance to develop appropriate protocols to respond to victims and to domestic violence perpetrators who work for them.
WHEN DOMESTIC VIOLENCE KILLS
Future Directions

Within the past year, the Denver Metro Domestic Violence Fatality Review Committee has undergone some dramatic changes, in an effort to act on the lessons learned thus far. The expansion of the Committee to include the surrounding jurisdictions has increased the membership, changed the structure of the committee and will increase the available sample of closed cases for review. The Denver-metro area generally accounts for 50% of the fatalities statewide. Data will continue to be gathered and analyzed for further refinement of the Risk Assessment Model, as well as provide vital information for education and awareness to system and community partners about prevention and intervention in domestic violence.

Several specific areas the Committee is looking to address, include:

There are a few perpetrators that received relatively light sentences and will be parole-eligible over the next few years. The Committee is interested in monitoring and perhaps attending the parole hearing in some of those cases. The concern expressed by the Committee is how domestic violence issues are evaluated and assessed throughout the incarceration and parole process. Domestic violence treatment is rarely, if ever, available during incarceration. Knowing the cyclical nature of domestic violence, these issues need to be addressed in releasing a perpetrator into the community. The Committee will be looking at ways to work with the Department of Corrections and the Parole Board to better incorporate assessment and screening of domestic violence issues with inmates under consideration for parole and community settings.

Given the need for increased collaboration with other professional fields identified in Chapter 4, the Committee will be developing strategies to act on this. In particular, we will be looking at ways to actively engage the health care community, to reinforce their obligation to report cases of domestic violence, as well as find earlier methods of intervention. Likewise, further collaboration with the mental health community is also essential and will be pursued by the Committee.
An on-going challenge for the Committee has been addressing the deficiencies in the data. Given the significant percentage of cases that have not had contact with any formal system, as well as the desire to have an understanding of the context of the homicide for all the cases, the Committee would like to develop a method to conduct interviews with the family, friends or others who knew the victim and the perpetrator. Information about the thoughts, fears, activity and motivations of the perpetrator and victim would help fill in much of the missing data and provide a more thorough background than what is often included in the court records. This was clearly demonstrated during one of the case reviews of a murder-suicide. The case came to the attention of the police on a Monday morning, when neither individual showed up for work. The perpetrator's co-worker went to the couple's house as soon as he did not report to work. Fifteen minutes after the victim should have reported to work, her co-worker called the police and asked them to do a welfare check due to concern about her safety. The perpetrator's co-worker and the police showed up at the house simultaneously to discover the tragic outcome. The Committee's lingering (and unanswered) question was what did those co-workers know that lead them to believe such a compelling response was warranted. There was no assumption that the individuals were tied up in traffic, had a longer than usual line at the coffee shop, or had simply overslept. For some reason, the co-workers had information that led them to believe (rightfully so) that checking on the couple's well-being was an appropriate response. The ability to do interviews with people who were directly involved with the victim and perpetrator will assist in a greater understanding of the dynamics and fill in many of the information gaps the Committee currently faces.

The other clear need the Committee hopes to fill is with additional community education and awareness. There are many efforts in the domestic violence community toward this end and the Fatality Review Committee will work to collaborate with other agencies to support this work. The Committee will also work to promote use of the Risk Assessment Model outlined in this publication, to increase awareness of possible indicators of domestic violence fatality.
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Memorandum of Understanding

The tragic effects of domestic violence that end in fatality led to the development of the Denver Metro Domestic Violence Fatality Review Committee. Project Safeguard and many other community domestic violence agencies, both governmental and community-based, came together in a cooperative effort to discuss fatalities related to domestic violence, to attempt to learn more about the dynamics of domestic violence and use that knowledge to help prevent future fatalities. The development of the Fatality Review Committee has promoted an honest and non-defensive exchange of information. The Mission Statement of the Committee reflects the philosophy and purpose of the group. The mission adopted by the Denver Metro Domestic Violence Fatality Review Committee states:

"The purpose of this Committee is to investigate domestic violence related fatalities. Information will be collected, correlated and disseminated to create better understanding and education in the dynamics of domestic violence related fatalities, for future prevention. It is recognized that the perpetrators of domestic violence are ultimately responsible for the death of victims. Thus, the goal of the Committee is
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not to place blame, but rather to better understand the dynamics of domestic violence when death is involved and thereby diminish the possibilities of future fatalities."

The goals set out by Project Safeguard and the Domestic Violence Fatality Review Committee are:

- Coordinate a multi-disciplinary Domestic Violence Fatality Review Committee for the purpose of reviewing and analyzing domestic violence related deaths.

- Create and maintain a comprehensive data base of the fatalities assessing victim and perpetrator demographics, relationship history, prior abuse history, prior interventions and resources utilized, to further analyze what may provide more effective intervention and prevention in future situations.

- Utilizing findings from the data collection, develop and refine a Risk Assessment Tool to help better identify high-risk domestic violence incidents.

- Identify trends and patterns in the cases reviewed to develop policy recommendations for earlier and more effective intervention in domestic violence cases.

- Develop and disseminate training materials to justice system personnel and the community at large, to help assess dangerousness and potential lethality.

To accomplish these goals, Project Safeguard relies on the commitment and participation of the Committee members. The members bring and share relevant information from his or her agency and discipline. While the case-specific information remains confidential within the confines of the Committee, individual members also act as a liaison to their agency or professional discipline by helping to explain agency policies and identify areas of improved response. Additionally, members convey information or concerns back to their agency and assist with the development and implementation of policy recommendations made by the Domestic Violence Fatality Review Committee.

Specifically, Project Safeguard secures funding through grants, provides office space and staff to administer the Committee through a Fatality Review Coordinator. This position is responsible for coordinating the various meetings, collection initial information from the homicide, district attorney or other court files, and maintains the database of cases reviewed. There is a system based and a community-based co-chair that share facilitation and planning of the monthly meetings and the case review process. Through Committee participation and in-kind contributions of time, Project Safeguard is provided with case-specific information for statistical purposes and social change policy ideas.

The undersigned understand that domestic violence fatalities are a community concern and the tragedy effect the entire community. We agree that it is in the
community's best interest to participate in the Denver Metro Domestic Violence Fatality Review information and data collection that will help lead to ideas in the future prevention of domestic violence fatalities.

It is agreed that the review process requires case specific sharing of records and other information subject to Colorado statutes and court directives. Case identification will only be utilized in this process to gain a complete understanding of the incident and to enlist interagency cooperation. Confidentiality is inherent in many of the reports, therefore there will be clear measures taken to protect confidentiality. This includes all members and visitors agreeing to confidentiality policies and procedures of the Committee. Additionally, no case identifying material may be taken from a meeting by persons other than those whose agency's provided the data.

Top this end, the undersigned agree to participate, support and assist the Denver Metro Domestic Violence Fatality Review Committee, sponsored by Project Safeguard.

__________________________________________________________________________  __________
Signature                                          Date

__________________________________________________________________________
Agency Affiliation
Confidentiality Agreement

DENVER-METRO DOMESTIC VIOLENCE FATALITY REVIEW COMMITTEE

MEMBER CONFIDENTIALITY AGREEMENT

The effectiveness of this committee’s work is conditioned upon the confidentiality of the review process and the information shared. I therefore agree to keep confidential any information obtained through the review process, and not use any material or information obtained for any reason other than which it was intended. However, I understand information discussed here may be subject to discovery, if civil or criminal action is pending. I will immediately notify the Domestic Violence Fatality Review Committee Co-chairs if I am subpoenaed for information in this capacity. I agree that information will only be released or discussed in the aggregate form outside of the committee meetings. No case identifying material will be taken from a meeting by any person other than whose agency provided the data.

I hereby agree to keep confidential all case related information discussed at the Domestic Violence Fatality Review Committee and all related subcommittee meetings. I also agree to abide by the confidentiality policies and procedures established by and for this committee.

SIGNATURE ___________________________ DATE ___________________________

AGENCY AFFILIATION ___________________________