

*Chesterfield County
Intimate Partner and Family Violence
Fatality Review Team*

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*Findings & Recommendations
October 2004*

**Chesterfield County Intimate Partner and Family Violence Fatality Review Team
Findings and Recommendations**

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Acknowledgements

The Chesterfield County Intimate Partner and Family Violence Fatality Review Team is a strong collaborative effort of team members who care deeply about preventing future domestic violence homicides. Those who serve on this team perform the difficult work of reviewing homicide cases to identify trends and to improve our system's response to domestic violence. Each member participated with purpose, commitment and insight. We are grateful to the following individuals who served on this team.

- *Cynthia Barnes, Chesterfield County Schools
- *Elizabeth Bernhard, Chesterfield County Victim-Witness Assistance Program
- *Beth Bonniwell, Chesterfield County Domestic Violence Resource Center
- *Chief Judge Lynn Brice, Chesterfield County Juvenile and Domestic Relations Court
- *Connie Brown, Domestic Violence Interventions, Inc.
Kris Bryant, Chesterfield County Community Corrections Services
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Janett Forte, Chesterfield County Domestic Violence Resource Center
- * Captain Paige Foster, Chesterfield County Police Department
- *Kelly Fried, Chesterfield County Community Services Board
- *Patricia Jones-Turner, Chesterfield County Domestic Violence Resource Center
Suzanne Keller, Office of the Chief Medical Examiner
Meghan Lamm, Chesterfield County Domestic Violence Resource Center
- *Sharon Lindsay, Chesterfield County Police Department
- *Beverly McGary, Chesterfield County Health Department
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Captain Tommy Nowlin, Chesterfield County Police Department
Nancy Oglesby, Chesterfield County Commonwealth's Attorney's Office
Carol Pond, Chesterfield County Victim-Witness Assistance Program
- *Lieutenant Carol Sharkey, Chesterfield County Sheriff's Dept.
- *Tisha Skinner, Chesterfield County Community Corrections Services
- *Elizabeth Smyers, Chesterfield County Commonwealth's Attorney's Office
- *Cindy Taylor, Chesterfield County University
- *Arlene Vassell, YWCA Women's Advocacy Program, Chesterfield Shelter
Major Barry Woody, Chesterfield County Sheriff's Office

* Designates current Team members

Executive Summary

In Chesterfield County, 45 homicides occurred during the years 1997 through 2001. Of those, 21 were domestic violence homicides. The Chesterfield County Intimate Partner and Family Violence Fatality Review Team was established in December 2001 to conduct reviews of intimate partner and family violence fatalities to prevent future family violence related deaths. Team members are representatives from 14 county and community agencies and organizations that provide domestic violence services. The Team reviews intimate partner homicide cases to identify trends in domestic homicides and to improve the system's response to families experiencing domestic violence. The team also works to support Chesterfield County's strategic goal of being the safest and most secure community of its size in the USA.

Of the 21 domestic homicides from 1997-2001, 18 were intimate partner homicides. Intimate partner homicides were defined as homicides that occurred between two parties with an intimate partner relationship, such as boyfriend/girlfriend or husband/wife. The team examined 16 intimate partner homicides that occurred during this period, providing the basis of this report. Eleven women, one man, and four children were killed. The remaining intimate partner homicides were not reviewed due to pending prosecution.

Seven primary facts and recommendations emerged from the information examined by the Fatality Review Team. They are:

- 1. 73% of the cases reviewed involved homicide/suicide.**
Recommendation: Increase training on awareness and suicide risk factors for families involved with domestic violence.
- 2. 82% of the perpetrators had a history of previously abusing their victim.**
Recommendation: Increase families' awareness of signs and symptoms of domestic violence. Resource material and hotline numbers should be more readily available to family members in public places (i.e. small businesses, grocery stores, ABC stores, pharmacies, salons, medical establishments, attorneys' office, churches, movie theaters, restaurants, and car repair shops). Victims should be strongly encouraged to participate in services that would increase their safety and knowledge of domestic violence patterns.
- 3. 73% of the deaths resulted from use of a firearm.**
Recommendation: Increase awareness about the connection between having access to firearms and deaths by domestic violence. There is a greater risk of domestic violence deaths if guns are available. If a victim is threatened or assaulted by a firearm, they should immediately contact police or a domestic violence hotline.
- 4. 55% of victims were separated or planning to separate from the perpetrator.**
Recommendation: Increase awareness of lethality risk factors including those associated with separation. If targeted audiences can perform lethality risk assessments that include questions about separation or be aware of the risk associated with separating, victim safety may be enhanced.

5. 55% of the cases reviewed had children under the age of 18 living at home.

Recommendation: Provide domestic violence education and training within the school system for staff and all adults working with children. Make resource materials more readily available in schools. Explore including healthy relationships information in classroom curriculum at all grade levels. Training should include how to recognize when children are impacted by domestic violence and when to report this to child protective services.

6. 55% of the cases reviewed revealed a history of substance abuse.

Recommendation: Families and friends need to be aware of the significant risk factors of domestic violence and substance abuse. Encourage substance abuse service providers, court programs, support groups and domestic violence programs to coordinate services. Substance abuse increases the risk of domestic violence occurring.

7. 64% of the cases reviewed revealed a prior arrest history of the perpetrator.

Recommendation: Identify repeat offenders and assess for increased services and or supervision needs i.e. specialized probation services, safety planning for victims, outreach services for family members, stricter sentencing recommendations.

The Fatality Review Team reached conclusions, developed recommendations, identified target groups, and provided detailed discussion for each of the seven recommendations. This information comprises the report that follows.

The goal of the Chesterfield County Intimate Partner and Family Violence Fatality Review Team is to increase public awareness of the correlation between the facts identified and the occurrence of intimate partner homicides.

It is our hope that by publishing this report, one or more lives may be saved.

Chesterfield County Intimate Partner and Family Violence Fatality Review Team

Findings and Recommendations

In 1999, the General Assembly enacted §32.1-283.3 of the Code of Virginia providing for the establishment of local/regional Intimate Partner and Family Violence Fatality Review Teams (hereinafter referred to as Fatality Review Team). A number of Chesterfield County domestic violence service providers attended the March 2001 conference entitled “National Trends in Fatality Review Teams”.

In April 2001 a core team began to develop a plan for how Chesterfield County could establish a local Fatality Review Team. The mission of the Chesterfield County Fatality Review Team is to conduct reviews of intimate partner and family violence fatalities to prevent future family violence related deaths. The team also works to support Chesterfield County’s strategic goal of being the safest and most secure community of its size in the USA.

The objectives of the group are as follows:

- To identify and describe trends and patterns of domestic violence related deaths in the county.
- To increase coordination and communication between agencies providing services to families experiencing domestic violence.
- To identify interventions aimed toward system improvement and change.

The following principles were agreed to by team members and guide the work of the team:

1. We recognize that the perpetrators of domestic violence are ultimately responsible for the death of victims.
2. We seek to promote a community response focusing on safety, not blame.
3. We seek to maintain the dignity and integrity of the victims and their surviving family members.

Overview of Chesterfield County

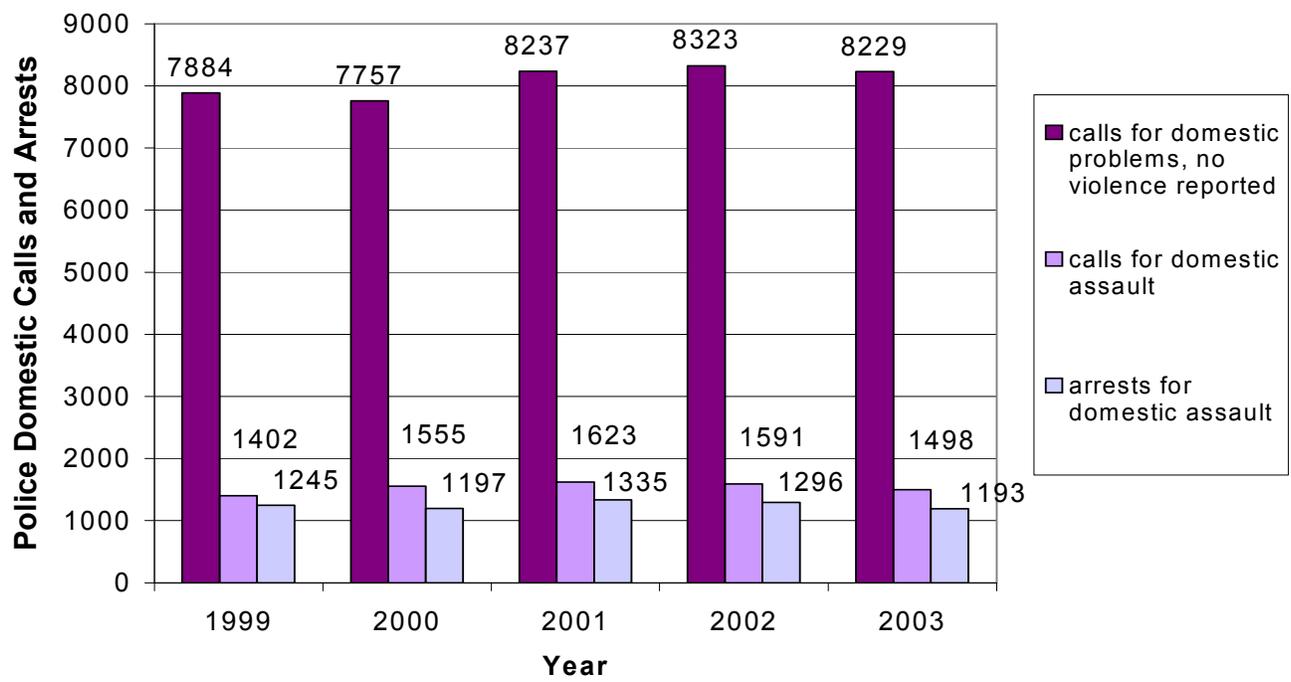
Chesterfield County is located in Central Virginia, in the mid-Atlantic region of the United States. The county is bounded by the cities of Richmond, Petersburg, Hopewell and Colonial Heights and is situated between the James and Appomattox Rivers. Chesterfield’s land area totals 446 square miles, with a population of 259,903. The 2000 census data states racial/ethnic characteristics as 76.7% white, 17.8% black, 2.9% Hispanic, 2.4% Asian, 1.4% multiple race/ethnicity and .3% other. Chesterfield County Public Schools educate approximately 55,000 students in Central Virginia. Chesterfield County has one of the lowest crime rates in the state and its streets are among the safest for Virginia residents and motorists. The county has more than 400 officers in the Police Department, 170 uniformed officers with the Sheriff’s office, 300 professional firefighters, and 270 volunteer firefighters. There is one public safety employee per 150 residents. The Chesterfield Emergency Communications Center receives at least one phone call every minute and dispatches an average 15 calls for service every hour.

At the Chesterfield County Police Department, domestic calls for service and arrests have remained fairly constant in the past five years, even though population has increased approximately 9%.

A domestic call for service is a 911 call involving a domestic situation between parties with some kind of dating or family relationship (ex. husband/wife, boyfriend /girlfriend, siblings). In most domestic calls, no physical violence is reported between the family members. Domestic violence arrests are arrests made for a domestic assault and battery or other related domestic crime, such as stalking or violation of a protective order.

The following chart indicates the police response to domestic calls. As you can see, the police are called frequently for domestic disturbances at homes, but most of the time violence is not reported. When violence or assault is reported, police are usually able to make an arrest if the evidence is sufficient.

Police Response to Domestic Calls in Chesterfield County



The Coordinated Community Response to Domestic Violence

Chesterfield County has been building a formal and comprehensive coordinated response to domestic violence for more than seven years. Our coordinated response effort works to change the climate of tolerance toward family abuse by institutionalizing practices and procedures, which centralize victim safety and offender accountability.

In an all-encompassing sense, the coordinated response efforts reflect a working partnership among a broad array of Chesterfield County's community agencies and organizations including law enforcement, courts, probation, human services, victim advocacy, medical, faith community, schools, health care, community service providers and citizens.

The county's response to domestic violence promotes an interagency effort, which centralizes victim safety and offender accountability in domestic assault cases. The county has demonstrated a commitment toward working together against domestic violence and striving for a seamless community response system where all elements of the county share responsibility for strengthening our efforts in addressing family violence.

Goals of Chesterfield County's Coordinated Response to Domestic Violence:

- To provide safety and self-determination for victims.
- To hold offenders accountable for their violence and for stopping it.
- To promote a clear understanding of domestic violence as a crime.
- To promote a coordinated and integrated community response.
- To transform personal, community and institutional attitudes so that domestic violence will not be tolerated.

The primary goal of domestic violence intervention is to stop the violence. Until that goal is achieved, the focus must be on providing safety for victims and accountability for offenders. Because domestic violence is a community problem, addressing these two issues requires the cooperation of all members of the community. Each program, department, and agency is an integral part of our community's response system. In order for our response to be the most effective in creating an environment, which is intolerant of domestic violence, collective action is imperative. Working together with mutual respect, dedication and the use of collective power, we will be stronger than the sum of our parts.

History

In 1989, the Chesterfield County Domestic Violence Task Force (CCDVTF) supported the opening of the Chesterfield YWCA Women's Shelter and the implementation of the Chesterfield County Police Department's mandatory arrest policy for domestic violence. In 1992, the CCDVTF became part of the Chesterfield County Commonwealth Attorney's Office and began working on a number of short and long-term projects. A consultant was utilized in 1995 to:

- Conduct a preliminary needs assessment of community services
- Hold victim and service provider focus groups
- Organize a multi-disciplinary summit to discuss the need for coordination
- Develop a comprehensive work plan for county domestic violence initiatives.

In 1995, the CCDVTF co-sponsored a community-wide summit on domestic violence. Over 100 key representatives of county government, criminal justice, the court system, and human service agencies attended the summit. The summit provided the groundwork to launch an integrated, community-wide response to domestic violence in Chesterfield County.

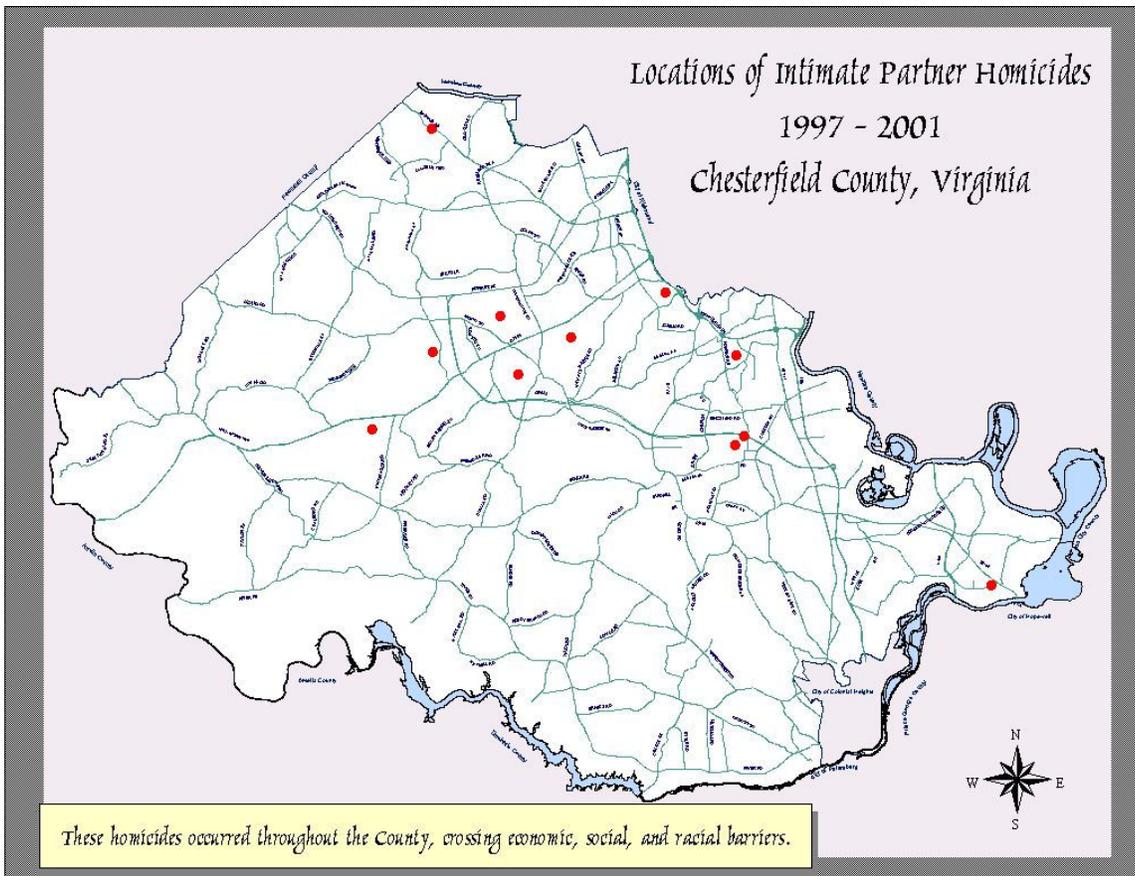
In 1996, the CCDVTF collaborated with the Chesterfield County Police Department in seeking Federal Community Oriented Policing (COPS) funds to develop a position within the police department to coordinate domestic violence services, provide officer training and assist domestic violence victims with accessing police services and community support. In late 1996, the task force also became the catalyst behind seeking Violence Against Women Act grant funds to create specialized domestic violence prosecution services within the Commonwealth's Attorney's Office, and to develop a centralized Chesterfield County Domestic Violence Resource Center to coordinate countywide domestic violence services.

Membership of the Fatality Review Team

Chesterfield County sought to form a Fatality Review Team, consisting of individuals and agencies affected by intimate partner fatalities. Those sought out as participants of the Chesterfield County Fatality Review Team were agency representatives involved in the cases who could make contributions to the team and the review process. A core team of representatives from the Domestic Violence Resource Center, Police Department, Victim Witness, Commonwealth's Attorney's Office, and Community Corrections met to develop strategies for obtaining county government support and approval for the project as well as outlining an action plan and timeline. The Chesterfield County Board of Supervisors established the Intimate Partner and Family Violence Fatality Review Team in December 2001. An informational letter was sent to county department directors explaining the project and seeking support. A second letter was sent seeking agency representatives to form the Fatality Review Team. Once representatives had been named, orientation meetings were held. After the review process began, representatives from several additional agencies were sought and joined the Fatality Review Team. The current Fatality Review Team membership is provided in Appendix A.

Case Selection

When examining the homicide rate in Chesterfield County, we see that domestic violence homicides account for almost half of all homicides. In the years 1997-2001, Chesterfield County Police reported a total of 45 homicides. Of that number, 21 homicides were due to domestic violence. A domestic violence homicide is a homicide between two family members, or two parties who had a significant dating relationship (i.e. ex-boyfriend killing an ex-girlfriend). Intimate partner homicide is defined as a homicide or a homicide/suicide that occurred between two parties with an intimate partner relationship, such as husband/wife or boyfriend/girlfriend. Of the 21 domestic homicides from 1997-2001, 18 were intimate partner homicides. **This report reviews the deaths of 16 victims of intimate partner homicide during this time frame.** The remaining intimate partner homicides were not reviewed due to pending prosecution.



This map outlines Chesterfield County and the general location of the homicides. As you can see, these homicides occurred all across the county, indicating that no family is immune from domestic violence. The homicides crossed economic, social and racial barriers.

Cases were selected by the Police Department, in consultation with the entire Fatality Review Team. Intimate Partner homicides occurring between 1997 and 2001 were reviewed. Cases were not eligible for review if there was a pending criminal investigation, prosecution, or appeal.

Confidentiality

One of the goals of the Fatality Review Team is to review the facts and circumstances surrounding the violent death of an intimate partner or family member. All of the information discussed in a fatality review is confidential either by statute or practice. By design, the Code of Virginia (§32.1-283.3) provides confidentiality protection to the review process in order to facilitate discussion that can lead to insights and interventions that might prevent these fatalities in the future. Confidentiality sign-off sheets were distributed and signed at each meeting when case information was discussed. This report only documents aggregate statistics and trends identified as a result of the reviews.

Case Demographics

The Fatality Review Team reviewed a total of eleven intimate partner homicide cases, which resulted in sixteen deaths. These homicides took place between 1997-2001. A total of eleven women, one man, and four children were killed. All of the perpetrators were men. Thirteen victims were Caucasian, one was African-American, one was Middle-Eastern and one was Asian. Ten of the perpetrators were Caucasian and one was African-American. The average age of the adult victims killed was 41 and the average age of the perpetrators was 49. Six victims were married to the perpetrator, three were not married, one was divorced, and one was engaged. Eight of the eleven cases (73%) were homicide/suicide cases. In these cases, the perpetrator killed the victim(s) and then killed himself.

Risk Factors

The following risk factors were found in the cases reviewed. It should be noted that case reviews were done with only the information provided by Fatality Review Team members, which often was incomplete.

History of Physical and Emotional Abuse

In nine cases (82%), the perpetrator mentally and emotionally abused the victim. Six cases (55%) involved a history of physical abuse on the victim.

Use of Firearm

In eight (73%) of the cases studied, a firearm was used to perpetrate the homicide.

Victim Reported the Abuse to Someone

In seven cases (64%), the victim reported the domestic abuse to someone, usually a family member or friend.

Criminal History

In seven cases (64%), the perpetrator had a criminal history. In three cases, the perpetrators had domestic violence arrests.

Recent Separation

In six cases (55%), the victim had either recently separated from the abuser or was planning to leave the abuser.

Substance Abuse

In six cases (55%), the perpetrator used drugs and/or alcohol. In four cases (36%), the victim used drugs and/or alcohol.

Prior Police Calls

In five cases (45%), the police had been called to the home to intervene in a domestic situation.

Pending Criminal Charges

In three cases (27%), there were pending criminal charges against the perpetrator involving domestic violence.

Mental Health Services

In three cases (27%), the victim had received mental health services. In three cases (27%), the perpetrator had received mental health services.

Threats to Kill Victim

In three cases (27%), the perpetrator had threatened to kill the victim.

Prior Protective Orders Issued

In three cases (27%), an Emergency Protective Order, valid for 72 hours, had been obtained by the police due to arrests for domestic violence. None of the victims had sought longer court issued protective orders against their abusers.

Domestic Violence Family History

In three cases (27%), there was a history of domestic violence in the perpetrator's family of origin. In two cases (18%), there was a history of domestic violence in the victim's family of origin.

Fatality Review Team Recommendations

(In no specific order)

1. Fact: In the cases reviewed, 73% involved homicide/suicide.

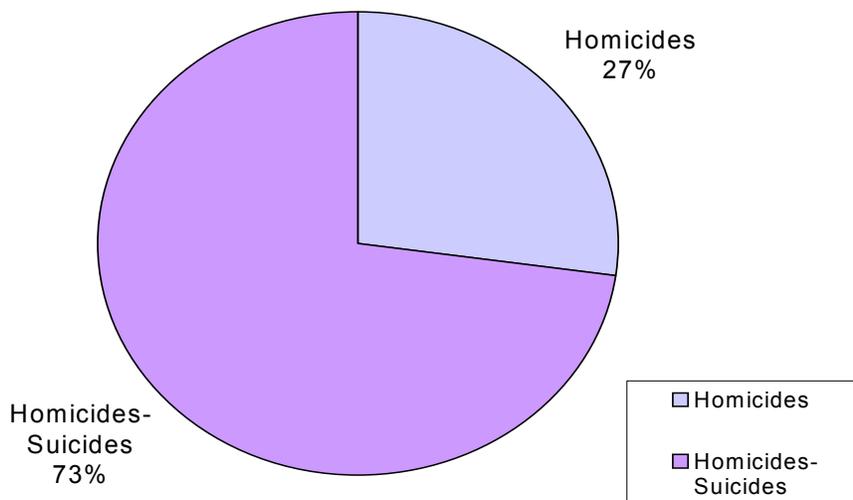
Conclusion: The majority of domestic violence homicides involved suicidal abusers.

Recommendation: Increase training on awareness and suicide risk factors for families involved with domestic violence.

Targeted Groups: general public and human services providers, families experiencing domestic violence; police department, social services, domestic violence programs, domestic violence task force

Discussion: Most domestic homicides in Chesterfield County are homicide/suicide. The abuser kills the victim (and sometimes the children) and then takes his own life. There are often suicidal risk factors present, such as depression, loss of employment, and the loss of a significant relationship. Sometimes families do not recognize that a threat to harm one's self could result in violence towards other family members. If an abuser has made threats to harm himself, these threats should be treated appropriately with crisis intervention and mental health services. Professionals working with families who experience domestic violence should receive adequate training on suicide risk assessment and the link between domestic violence homicide and suicide. The general public should also receive this awareness information to better assist a loved one who may be suicidal and asking for help.

16 Intimate Partner Homicides Chesterfield County, 1997 - 2001



- 2. Fact: In the cases reviewed, 82% of the perpetrators had a history of psychologically, emotionally and verbally abusing their victims; 55% used physical abuse against their adult victims.**

Conclusion: Victims often do not self-identify as being a victim of domestic violence. Often victims and abusers will discuss their problems with others prior to going to police. Therefore, it is helpful for friends and family members to know the resources available to help both the victim and the offender.

Recommendation: Increase families' awareness of signs and symptoms of domestic violence. Resource material and hotline numbers should be made more available to family members in public places (i.e. small businesses, grocery stores, ABC stores, pharmacies, salons, medical establishments, attorneys' office, churches, movie theaters, restaurants, and car repair shops).

Victims should be strongly encouraged to participate in services that would increase their safety and knowledge of domestic violence patterns.

Targeted Groups: Collaborative effort among police department, mental health, social services, domestic violence resource center, domestic violence task force, probation, court services, family workers, victim services, human service professionals, licensed health and mental health professionals, faith community, and schools.

Discussion: Victims often do not self-identify as being victims of domestic violence. Victims may not self-identify because they don't view their relationship as abusive. Many of the victims minimize the level of abuse and violence they experience. It is important that victims, their family, friends, etc. know that there are different types of abuse, psychological & physical, and examples of each type of abuse. In three of the homicides reviewed, there was a history of emotional abuse towards the victim, with no physical abuse reported. These cases demonstrate how emotional abuse can quickly escalate into a dangerous situation, sometimes resulting in homicide. Listed below are examples of psychological/emotional & physical abuse.

Psychological/Emotional Abuse Includes:

Constant verbal abuse, yelling, name calling, constant criticism, excessive possessiveness, manipulation through threats, harassment, isolation from family and friends, humiliation, deprivation of physical and economic resources, destruction of personal property, threats of violence, threatening custody/safety of children, and abusing pets.

Physical Abuse Includes:

Pinching, scratching, tripping, pushing, shoving, pulling hair, slapping, twisting arms, shaking, biting, hitting, punching, kicking, choking, smothering, throwing objects at the victim, holding to prevent from leaving, driving recklessly or forcing the victim off the road.

3. Fact: In the cases reviewed, 73% involved death by a firearm.

Conclusion: Access to firearms increases the risk of domestic homicide.

Recommendation: Increase awareness about the connection between having access to firearms and deaths by domestic violence. There is a greater risk of domestic violence deaths if guns are available. If a victim is threatened or assaulted by a firearm, they should immediately contact police or a domestic violence hotline.

Recommendation: All service providers should assess for availability of firearms when working with families who experience domestic violence. Targeted groups should be educated about the laws regarding domestic violence and firearms and should use the law to the fullest extent to increase safety for victims and families.

Targeted groups: General public, mental health, social services, schools, magistrates, court services, domestic violence programs, police, victim witness, probation

Discussion: When reviewing our cases, we found no evidence that any of the firearms were obtained or possessed illegally. However, they were the weapons of choice in 73% of the domestic homicides. Our goal in this recommendation is to educate service providers who are working with victims and families on the laws of firearms that pertain to domestic violence. If someone becomes aware of a violation of law regarding firearms and domestic violence, they should contact the police immediately or encourage the victim to do this. The availability of firearms to domestic violence offenders is a lethal risk factor that should be addressed with families in safety planning.

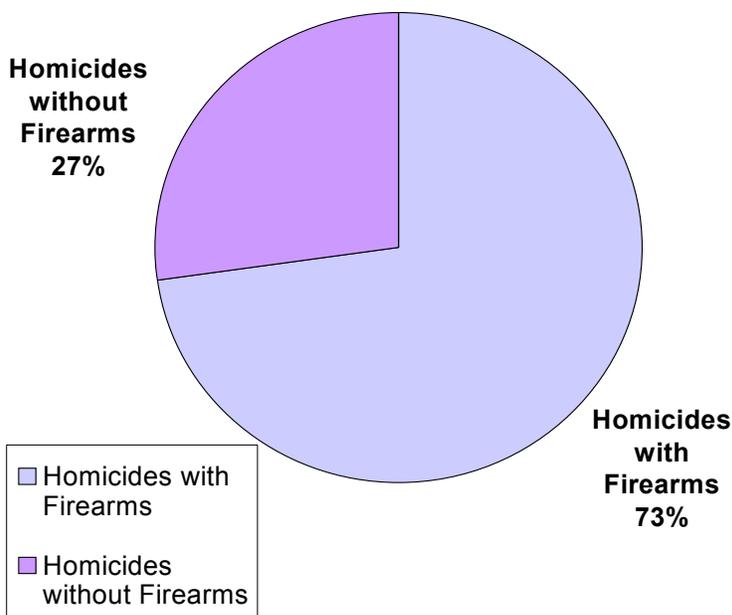
The Federal Gun Control Act (18 USC 922(g)(8)) – It is a federal crime for any person convicted of a misdemeanor crime of domestic violence, such as domestic assault and battery, to possess, purchase, or receive firearms or ammunition.

The Federal Gun Control Act (18 USC 922 (g)(9)) – It is a federal crime for a person who is subject to a domestic violence protective order to possess a firearm or ammunition. This law excludes temporary ex parte orders (issued with only one party present) and does not apply to on-duty government officials in law enforcement or the military.

Virginia (§18.2-308.1:4) – It is a class 1 misdemeanor for the subject of a domestic violence, stalking, or child abuse protective order to purchase or transport a firearm while the order is in effect.

Virginia (§18.2-56.2) It is a class 3 misdemeanor for a person to leave a loaded, unsecured firearm in such a manner as to endanger a child under the age of fourteen.

**Use of Firearms in 16 Intimate Partner
Homicides
Chesterfield County, 1997-2001**



4. Fact: In the cases reviewed, 55% of victims were recently separated or planning to separate from the perpetrator.

Conclusion: Victims who have either recently separated or plan to separate from a violent partner are at greater risk of harm and/or serious injury.

Recommendation: Increase awareness of lethality risk factors including those associated with separation. If targeted audiences can perform lethality risk assessments that include questions about separation or be aware of the risk associated with separating, victim safety may be enhanced.

Targeted groups: Divorce attorneys, court in-take workers, DSS staff, general public, family and friends of families experiencing domestic violence.

Discussion: Separation is a risk factor that is usually connected with lethal intimate partner violence. Separation can include anything from filing for divorce to verbal statements to friends and family members about leaving an abusive relationship. In 2002, the Office of the Chief Medical Examiner found that 28 of 43 intimate partner homicides in Virginia were associated with a relationship that had ended or was ending. Of those 28 cases, there were 2 divorces filed, 7 separations, 10 break-ups, and 9 cases in which the victims planned to end the relationship. Most of our Chesterfield County domestic homicides involved victims who were planning to leave their abuser.

There are other lethality risk factors or indicators; the more indicators that are present in a relationship the higher a victim's risk of future violence or death. In no particular order, the Office of the Chief Medical Examiner lists the following indicators: pet abuse, cultural influences, intimidation/threats, acute mental health problems, depression, hostage taking, sexual violence, stalking, fantasies of homicide or suicide, firearms, access to victim, abuser's lack of respect for law, destruction of property, isolation of victim/perpetrator/both, prior calls to the police, sense of ownership of the victim by the perpetrator, obsession with partner or family, timing-fear of losing partner, drug or alcohol consumption, public displays of violence toward victim, rage, threats of homicide or suicide, and previous episodes of violence.

5. Fact: In 55% of the cases reviewed, children under the age of 18 were living in the home. Four of the nine children (44%) in these homes were killed.

Conclusion: Children are killed by domestic violence escalating in the home.

Recommendations: Provide domestic violence education and training within the school system for staff and all adults working with children. Make resource materials more readily available in schools. Explore including healthy relationships information in classroom curriculum at all grade levels. Training should include how to recognize when children are impacted by domestic violence and when to report this to child protective services.

Targeted groups: School personnel, daycare providers, churches, healthcare providers, family social workers, family counselors, girl scouts, boy scouts and coaches of community teams, staff and volunteers in after school and summer programs.

Discussion: It is obvious from the cases that we reviewed that children are impacted by domestic violence. Our goals in this recommendation are to create norms that reflect healthy relationships and help establish positive identities.

6. Fact: In 55% of the cases reviewed, the perpetrator had a history of alcohol and/or drug use. In 36% of the cases reviewed, the victim had a history of alcohol and/or drug use. There was a significant relationship between domestic violence and substance abuse in the reviewed deaths.

Conclusion: A majority of these cases involved substance abuse, making it a significant risk factor.

Recommendation: Families and friends need to be aware of the significant risk factors of domestic violence and substance abuse. Encourage substance abuse service providers, court programs, support groups and domestic violence programs to coordinate services. Substance abuse increases the risk of domestic violence occurring.

Targeted groups: Substance abuse service providers, court programs, domestic violence programs

Discussion: Substance abuse is not a cause of domestic violence, but a contributing factor and often a coping mechanism for individuals. Since power and control are identified as the roots of domestic violence, it is believed that domestic violence will occur in the absence and/or presence of substance

abuse related problems. Although we recognize that substance abuse is not the cause of violent behavior, it certainly is accepted as a contributor. Substance abuse is only one factor of influence within the spectrum of violence. It is important to acknowledge that substance abuse problems can increase the likelihood of an abuser to misinterpret and/or distort the actions of a partner. Likewise, victims of violence suffering from problems of addiction often struggle with making rationale decisions and healthy choices. Therefore, situations can become more complicated, creating inappropriate responses of anger and hostility. Substance abuse is often used a substitute for coping with emotional, physical and financial stressors.

Our goal in this recommendation is to stress the importance of understanding the correlation between violence and addiction. In addition, the goal is to create awareness in family members, service providers and perpetrators and victims of violence.

7. Fact: In 64% of cases reviewed, the perpetrator had a record of prior arrest(s).

Conclusion: The majority of the perpetrators had prior arrests. Almost half of these arrest records involved domestic violence arrests

Recommendation: Identify repeat offenders and assess for increased services and or supervision needs i.e. specialized probation services, safety planning for victims, outreach services for family members, stricter sentencing recommendations.

Targeted Groups: Community Corrections Probation Officers, Social Services, Victim Witness, Police, Commonwealth's Attorney, batterer intervention service providers, counselors.

Discussion: It is generally accepted among many criminal justice professionals that the best predictor of future criminal activity is a history of criminal activity. This premise held true in the review of our cases. Specialized units for domestic violence intervention can focus services on identifying and targeting repeat offenders. These cases are higher risk and should be treated as such.

Domestic Violence Community Awareness Model

EDUCATION

Incorporate Healthy Relationship Campaigns, programming and curriculum focused on Violence Prevention Initiatives

PUBLIC AGENCIES

Improvements in “best practice” through assessments, policy & procedure that will focus training on the correlation between Domestic Violence >>Suicide>>Homicide

BUSINESSES

Train staff and personnel on signs and indicators of domestic violence. Make resources available to patrons.

Public & Private School

Criminal Justice Services

Civic Groups

Higher Education

Human Services

Retail Merchants

Technical Schools

Legislative Policy Makers

Faith-Based Groups

Service Providers



Enhanced client intake forms

Development of cooperative working agreements

Enhanced client social histories

Specialized personnel

Practice Coordinated-Community Response

Distribute resource materials in every office



Regional Networking

Public Service Announcements

Outreach Volunteerism

Cooperation with State Domestic Violence Coalitions

Limitations of Review

During the course of case reviews, some factors were identified as limiting the Fatality Review Team's ability to review and/or obtain specific information. The Fatality Review Team will work together to minimize these factors in future reviews.

1. Records Were Purged and Information Was Unavailable

Criminal histories are purged after death and county agencies have different retention guidelines for case records. Many agencies did not have files that may have been helpful for the reviews because the files had been purged.

Eight of the eleven cases reviewed were homicide/suicide, as opposed to cases wherein an arrest and prosecution occurred. There is generally far less information gathered when the perpetrator commits suicide as opposed to a criminal defendant being prosecuted which may include a psychological evaluation, presentence report, witness testimony, and victim impact testimony. Many of the cases had limited information available in the review due to the suspect's suicide, which limited the Fatality Review Team in determining prevention strategies.

2. Lack of Uniform Interagency Information

No single county agency records or tracks all of the risk factors previously identified in this report. After the risk factors were identified, many agencies indicated that it would be possible to include most or all of these factors in future intake and assessment procedures.

Prevention of Future Domestic Violence Homicides

One of the best ways the Fatality Review Team can work to prevent future domestic violence homicides is to continue the practice of Fatality Review. The team will continue to meet and review appropriate intimate partner domestic violence homicides, as well as identify trends to learn from these cases. The team will also assess representation from the community and evaluate whether additional partners should be invited to join the team.

Several positive programs were identified in the review process, which deserve mention and praise. Many agencies in Chesterfield County addressing domestic violence employ specialized units and positions to address the specific needs and challenges of domestic violence cases. The Commonwealth's Attorney's Office has a special team of prosecutors who prosecute all domestic violence and child abuse cases. The Victim Witness Assistance Program has a special unit of four victim advocates who work with victims of domestic violence and sexual assault. Community Corrections Services has a special unit of probation officers who only supervise domestic violence offenders. The Chesterfield County Police Department has a Domestic Violence Coordinator who reviews the work of officers in handling domestic violence cases, as well as assists victims. Each of these specialized units have received additional training on handling domestic violence cases, victim safety and offender accountability.

The Police Department and Chesterfield Mental Health created an innovative program that addresses children exposed to domestic violence. The REACT (Referral and Education to Assist Children in Trauma) involves patrol officers making referrals for families experiencing domestic violence when children are present. Specialized groups for children who witness domestic violence assist parents in helping their children. Referrals are made to Child Protective Services by the Police Department for children and teens that witness domestic violence

Several years ago, the Domestic Violence Resource Center and Child Protective Services collaborated to bring together representatives from county agencies to discuss our community's response when domestic violence and child abuse/neglect co-exist in families. A protocol was written to guide the handling of cases where children are exposed to domestic violence in the home. This work group continues to meet regularly to monitor the use of the protocol and any issues in this area that need to be addressed. Members of this work group include representatives from social services, police, probation, prosecution, victim/witness, and mental health.

Another helpful team in the county is the Criminal Justice Interagency Committee. This group monitors the criminal justice system response to domestic violence cases, such as criminal cases and protective orders. Juvenile and Domestic Relations Court judges actively participate with other members, including police, sheriff's department, prosecutors, victim witness, victim advocates, and probation. This committee has supported the expedited domestic violence docket in Juvenile and Domestic Relations Court, which sets domestic violence cases for trial quickly to facilitate safety for the victim and accountability for the abuser.

Another vital service for families in Chesterfield County is the YWCA Women's Advocacy Program, a non-profit domestic violence program. The YWCA offers a 24-hour hotline, shelter for victims and their children, and services such as counseling and a support groups for victims of domestic violence.

The Chesterfield County Domestic Violence Resource Center is a tremendous asset to the county in providing victim services, outreach to the Hispanic community about domestic violence, and community collaboration building and training. This small agency has brought together many Chesterfield County departments and programs to address the community issue of domestic violence and to make system improvements.

When considering services for offenders of domestic violence, Chesterfield County is fortunate to have several state-certified Batterers Intervention Programs. These programs provide intensive group treatment for abusers, who usually are court-ordered to complete the program. The treatment is eighteen to twenty-four weeks long and the abuser is usually monitored on probation until successful completion. Vendors for these programs in Chesterfield County include Domestic Violence Interventions, Inc.; Frank Manners and Associates; and Commonwealth Catholics Charities (treatment provided in Spanish).

The Chesterfield County Domestic Violence Task Force, Inc. has also contributed to the coordinated response to domestic violence. This non-profit group meets monthly to provide education and training to the community about domestic violence. It also supports the Carolyn Miller Emergency Fund, a financial assistance program for Chesterfield County victims fleeing an abusive relationship. Victims

Appendix A

Current Membership- 2004 Chesterfield County Intimate Partner Fatality Review Team

Cynthia Barnes, Chesterfield County Schools
Elizabeth Bernhard, Chesterfield County Victim-Witness Assistance Program
Beth Bonniwell, Chesterfield County Domestic Violence Resource Center
Chief Judge Lynn Brice, Chesterfield County Juvenile and Domestic Relations Court
Connie Brown, Domestic Violence Interventions, Inc.
Cindy Duffus, Chesterfield County Juvenile and Domestic Relations Court Services
Captain Paige Foster, Chesterfield County Police Department
Kelly Fried, Chesterfield County Community Services Board
Patricia Jones-Turner, Chesterfield County Domestic Violence Resource Center
Sharon Lindsay, Chesterfield County Police Department
Beverly McGary, Chesterfield County Health Department
Dawn Morris, Chesterfield County Victim-Witness Assistance Program
Joan Norfleet, Chesterfield-Colonial Heights Department of Social Services
Lieutenant Carol Sharkey, Chesterfield County Sheriff's Dept.
Tisha Skinner, Chesterfield Community Corrections Services
Elizabeth Smyers, Chesterfield County Commonwealth's Attorney's Office
Cindy Taylor, Chesterfield County University
Arlene Vassell, YWCA Women's Advocacy Program, Chesterfield Shelter

Appendix B

Definitions Used in Report

Domestic Violence Homicide: Homicide between two family members, or two parties who had a significant dating relationship, i.e. ex-boyfriend killing an ex-girlfriend

Intimate Partner Homicide: Homicide or a homicide/suicide that occurred between two parties with an intimate partner relationship, such as husband/wife or boyfriend/girlfriend.

Domestic Call for Service: A 911 call involving a domestic situation between parties with some kind of dating or family relationship, i.e. ex. husband/wife, boyfriend/girlfriend, siblings.

Domestic Violence Arrests: Arrests made for a domestic assault and battery or other related domestic crime, such as stalking or violation of protective order.

Appendix C

RESOLUTION TO ESTABLISH THE CHESTERFIELD COUNTY INTIMATE PARTNER AND FAMILY VIOLENCE FATALITY REVIEW TEAM FOR THE PURPOSES OF IDENTIFYING AND DESCRIBING TRENDS AND PATTERNS OF DOMESTIC VIOLENCE RELATED DEATHS IN THE COUNTY; INCREASING COORDINATION AND COMMUNICATION BETWEEN AGENCIES PROVIDING SERVICES TO FAMILIES EXPERIENCING DOMESTIC VIOLENCE; AND IDENTIFYING INTERVENTIONS AIMED AT SYSTEM IMPROVEMENTS

WHEREAS, family and intimate partner violence has destructive consequences upon individuals and families within our County; and

WHEREAS, the General Assembly enacted Section 32.1-283.3 of the Code of Virginia, 1950, as amended, to permit Chesterfield County to establish a family violence fatality review team to examine fatal family violence incidents and to create a body of information to help prevent future family violence fatalities; and

WHEREAS, careful examination of family and intimate partner violence fatalities will yield results to help prevent similar tragedies from recurring; and

WHEREAS, a thoughtful and nonjudgmental method of evaluating the events that lead to family and intimate partner violence fatalities will create a safer community.

NOW, THEREFORE BE IT RESOLVED, that the Chesterfield County Fatality Review Team will identify gaps in system responses and work to provide increased communication and collaboration amongst the agencies involved.

AND, BE IT FURTHER RESOLVED, that the Chesterfield County Fatality Review Team will operate under the assumption that all persons and agencies involved care deeply about preventing violence within the family and operate in good faith, using the best judgment and information available at the time.

AND, BE IT FURTHER RESOLVED, that the Chesterfield County Fatality Review Team will offer recommendations to Chesterfield County service providers which benefit our community and improve our public safety.

AND, BE IT FURTHER RESOLVED, that Chesterfield County Board of Supervisors will establish an Intimate Partner Family Violence Fatality Review Team and the Team shall establish local rules and procedures to govern the review process.

AND, BE IT FURTHER RESOLVED, that the Chesterfield County Intimate Partner Fatality Review Team be established and that the following individuals may serve on the Team pursuant to Section 32.1-283.3 (D) of the Code of Virginia:

The Chief Judge of the 12th Judicial Juvenile and Domestic Relations Court, or another Juvenile & Domestic Relations Court Judge designated by the Chief Judge
The Commonwealth Attorney of the County of Chesterfield or designee
The Sheriff for the County of Chesterfield or designee
The Chief Magistrate for the County of Chesterfield or designee
The Chief of Police for the County of Chesterfield or designee
The Director of Chesterfield 12th Judicial District Court Services Unit or designee
The Director of Chesterfield-Colonial Heights Community Corrections Services or designee
The Director of Chesterfield Community Services Board or designee
The Director of Chesterfield Victim Witness Assistance Program or designee
The Director of Chesterfield - Colonial Heights Health Department or designee
The director of the Chesterfield-Colonial Heights Department of Social Services or designee
The coordinator of the Chesterfield County Domestic Violence Resource Center
The Chesterfield County Criminal Justice Planner
A representative from a local Batterer Intervention Program
The Director of the YWCA or designee
Other disciplines/members may serve on the team at the discretion of the team.

AND, BE IT FURTHER RESOLVED, that this action provide that the Chesterfield County Domestic Violence Resource Center will serve as staff support for the Fatality Review Team and shall work with a core team of County domestic violence and criminal justice staff to support the organization and maintenance of the Fatality Review Team.

Adopted at a regular meeting of the Board of Supervisors of Chesterfield County, Virginia, held December 12, 2001.

The numbers on the front cover represent statistics from homicides in Chesterfield County, Virginia from 1997-2001. There were **45** homicides committed. **21** of those cases were domestic violence homicides, of which were **18** intimate partner homicides.

*This report reviews the deaths of **16** victims killed in intimate partner homicides, to include **11** women, **4** children and **1** man. **8** Perpetrators committed suicide after killing an intimate partner.*



Providing a FIRST CHOICE community through excellence in public service.

***For more information, please contact the
Chesterfield County Domestic Violence Resource
Center at (804) 768-4783***