Roanoke Valley Regional
Family and Intimate Partner Violence
Fatality Review (FIPVFR) Team

A Review of Family and Intimate Partner Violence Fatalities in the City of Roanoke, Roanoke County, the Town of Vinton And the City of Salem from 1998-2012

2016 Report

Dear Community Leaders:

On behalf of the Roanoke Valley Regional Family and Intimate Partner Violence Fatality Review Team (Team) and the City of Roanoke Domestic Violence Task Force (Task Force), we are pleased to present the *2016 Report, A Review of Family and Intimate Partner Violence Fatalities in the City of Roanoke, Roanoke County, the Town of Vinton and the City of Salem from 1998-2012*. The Report highlights findings and recommendations from the Team's review of randomly selected family and intimate partner violence fatality cases (homicides, homicide/suicide) from 1998 to 2012. The findings and recommendations included within the Report were endorsed by the Team at its January, 2016 meeting.

The Task Force led by Council Member Sherman P. Lea, Sr., since its creation in 2006, recommended establishment of this multi-jurisdictional and multi-disciplinary Team. The Team was established in December 2009. In July 2009, Roanoke City Council adopted a resolution to authorize the establishment of the Team. The Roanoke County Board of Supervisors (February 2001), Salem City Council (May 2009) and the Vinton Town Council (September 2009) adopted similar resolutions endorsing the creation of the Team.

The participating members of the Team include various agencies, departments, hospitals and other community organizations that regularly work with victims, offenders and families whose lives are impacted by violence. Team members have various professional backgrounds that include law enforcement, attorneys, mental health, probation/parole, health-care, the State Medical Examiner's Office, human services and advocates. Case review meetings are held quarterly with a mission to try to reduce and prevent future deaths related to family and intimate partner violence. Through review of past cases of domestic violence fatalities, the Team works to identify red flags for homicide risk, and strengths, and gaps in community services.

The recommendations made in this Report are based on careful analysis of the data and current best practices with a focus on developing tools that allow for a better understanding of how and why violence happens. The mission of every review is to reduce future deaths or disabilities. The center of every review is the victim or victims whose lives have been cut short as a result of family and intimate partner violence, as well as the impact upon the survivors left behind. A review would be incomplete without careful analysis also of offender red flags, characteristics, behaviors, and adverse childhood events.

On behalf of the Team and the Task Force, we would like to thank you for your continued commitment to supporting efforts addressing family and intimate partner homicides and homicide/suicides in the Roanoke Valley. We ask you to work with the Team and Task Force in implementing the recommendations set-forth in the Report, so that, together we can work to eliminate these premature, violent, and preventable deaths.

In Kindest Regards,
/s/ Melissa Ratcliff Harper
Melissa Ratcliff Harper, MSN, APRN, SANE-A-P
Coordinator
Roanoke Valley Regional Family and IPV Fatality Review Team
/s/ Sherman P. Lea Sr.
Sherman P. Lea, Sr.
Roanoke City Council Member

Table of Contents

Acknowledgements 4

Mission Statement 5

Purpose of Fatality Review 6

History of the Team 7

Team-members 9

About the Roanoke Valley 12

Fatality Review Findings 13

Family and IPV Homicide Statistics (Local and State 21

Suicides with Co-Occurring Violence and IPV Problems 23

National DV-Related Statistics 26

Recommendations 28

Glossary 41

References 42

Acknowledgements

The Core Team gratefully acknowledges:

- The Roanoke City Council, the Roanoke County Board of Supervisors, Vinton Town Council and the Council of the City of Salem.

- The leadership of our participating organizations for allowing our team the opportunity to review family and intimate partner violence fatalities within the Roanoke Valley.

- The individual team members for their contributions as each case was methodically reviewed throughout each year (see Team membership list).

- The recommendation subcommittee (current and past) as follows for their unending commitment in analyzing the data, reviewing team findings, developing recommendations and preparing the 2016 Preliminary Report as follows:

    - Melissa Harper (lead author)
    - Jennifer Bath
    - Debra Davidson
    - Sue Goad
    - Evelyn Jordan
    - Dr. Klaire Mundy, PsyD
    - Diana Perkinson
    - Heather Sellers
    - Stacy Sheppard
    - Jimmy Testerman
    - Dr. Amy Tharp, M. D.

- Emma Duer and Dr. Virginia Powell, Ph.D. for their technical assistance in data extraction and as our team prepared the 2016 report.

- Lastly, victims whose lives were cut short as a result of family and intimate partner violence, as well as survivors, left behind to deal with the aftermath.

Mission Statement

The mission of the Roanoke Valley Regional Family and Intimate Partner Violence Fatality Review Team is to try to reduce and prevent future deaths related to family and intimate partner violence. Through review of past cases of domestic violence fatalities; the Team will identify the strengths and gaps in community services and make recommendations to help address these types of cases. The Team will also increase coordination and communication between all area agencies, departments, offices and systems so we may better serve the community and its victims. The Team recognizes that domestic violence offenders are ultimately responsible for the death of victims. Rather than assigning blame, the purpose of the Team is to better understand how and why violence happens and to reduce any future deaths or disabilities.

Purpose of Fatality Review

The purpose of fatality review in the Roanoke Valley is as follows:

1. To describe trends and patterns of family and intimate partner violence related fatalities.

2. To identify high-risk factors, current practices, gaps and strengths in system responses and barriers to safety in family and intimate partner violence situations.

3. To develop a better understanding of these events through multi-disciplinary collaboration.

4. To enhance cooperation among team participants.

5. To develop a greater understanding of individual team participants policies, procedures and roles.

6. To educate the public, policy makers, funding sources and service providers in regard to fatalities related to family and intimate partner violence and strategies for intervention.

7. To recommend policies, practices and services that will promote collaboration among service providers and facilitate prevention of fatalities related to family and intimate partner violence.

8. To improve family and intimate partner violence data collection among collaborating agencies.

History of the Roanoke Valley's Fatality Review Team

"In 1998, the Virginia Commission on Family Violence Prevention convened a task group to assess the need for family and intimate partner violence fatality reviews in Virginia. The Commission's task group concluded that legislation was needed to provide authority to conduct the reviews and ensure confidentiality. As a result of the task group's work, the Commission requested the introduction of legislation (HB2185/SB1035) relating to family or intimate partner violence fatality review teams and family or intimate partner violence fatality surveillance. In 1999, the General Assembly enacted statute 32.1-283.3 of the Code of Virginia. Along with the development of a model protocol, this statute provides for the establishment of local/regional family violence fatality review teams and the creation of a surveillance system for detection and analysis of family violence homicides" (VDH, 2002, p. 2).

In February 2006, a Domestic Violence Taskforce spearheaded by Councilman Sherman Lea was formed to study problems, appropriate intervention and strategies related to domestic violence in the City of Roanoke. Community concerns which led to the formation of the taskforce included increases in domestic related homicides during the previous three years, lack of consistent enforcement for offenders of domestic violence and the apparent increase in domestic related assaults in the City of Roanoke. The taskforce studied information related to domestic violence, consulted with service providers in the community, and researched best practices in other jurisdictions. After analyzing well-reasoned, dedicated, and experienced perspectives in all aspects of this very complex issue, the taskforce presented recommendations to City Council and requested its support on a number of recommended service and legislative changes.

In December 2006, the taskforce recommended that City Council adopt a resolution authorizing the City of Roanoke to participate in a regional Family Violence Fatality Review Team pursuant to §32.1-283.3 of the Code of Virginia. On July 20, 2009 Roanoke City Council adopted RESOLUTION NO. 38535-072009, A RESOLUTION AUTHORIZING THE CITY'S PARTICIPATION IN A REGIONAL FAMILY VIOLENCE FATALITY REVIEW TEAM. Previously, on February 27, 2001, Roanoke County's Board of Supervisors adopted a resolution authorizing that the Domestic Violence Coordinating Council establish a regional Family Violence Fatality Review Team. On May 11, 2009, the Council of the City of Salem, Virginia adopted RESOLUTION 1137, a RESOLUTION ESTABLISHING A MULTIJURISDICTIONAL FAMILY VIOLENCE FATALITY REVIEW TEAM. On September 1, 2009, Vinton Town Council adopted RESOLUTION 1839, A RESOLUTION TO ESTABLISH A MULTIJURISDICTIONAL FAMILY VIOLENCE FAMILY REVIEW TEAM.

The regional Family Violence Fatality Review Team consists of representatives from the 23rd Judicial District of Roanoke, City of Salem, Roanoke County and the Town of Vinton. Representatives from the Court, service providers, and attorneys-at-law met with the Chief Medical Examiner's Office to discuss the creation of a Regional Family Violence Fatality Review Team. All jurisdictions were in support of the creation of a regional team.

The Roanoke Valley Regional Family and Intimate Partner Violence Fatality Review (RVRFIPVFR) Team Protocol was adopted on December 10, 2009 by the Core Team. The RVRFIPVFR team began reviewing cases March 20, 2010 with the ultimate purpose of reducing the incidence of fatal family and intimate partner violence and creating a safer community.

Review Team Members

*** Denotes Core Team**
+ Founding Member

Chief Howard B. Hall
Honorary Chairperson
Roanoke County Police Department

Interim Chief Jeff Dudley
Honorary Chairperson
Vinton Police Department

Chief Chris Perkins
Honorary Chairperson
Roanoke City Police Department

Chief Tim Guthrie
Honorary Chairperson
City of Salem Police Department

Amanda Stone
Forensic Nurse Program
Lewis Gale Medical Center

Beth Lipes
Director
Court Community Corrections

Ellen S. Weinman*+
Attorney
Weinman Law

Katie Van Patten*+
Utilization Mngt. Coordinator
City of Roanoke-Child Service Act
Ret., Court Community Corrections

Melissa Ratcliff Harper, MSN, APRN, SANE-A-P*+
DVFR Coordinator
Forensic Nurse Examiner
Carilion Clinic-Carilion Roanoke Memorial Hospital ED

Steve Ratliff, LPC
Division Director, Adult/Family Serv.
Blue Ridge Behavioral Healthcare

Breyon Fraction, DCPO
Mental Health Specialist
Department of Corrections
Adult Probation and Parole-District 15

Randy Leach*
Commonwealth's Attorney
Roanoke County CA Office

Aaron Lavinder, JD*+
Assistant CA
Roanoke County CA Office

David Billingsley
Assistant CA
Roanoke City CA Office

Jon D. Perry*+
KCPD Ret. (Homicide)
VSP Ret. (Homicide)

Laura Maynard
Senior Probation Officer
23rd District CSU

Matt Pollard* +
Attorney
Bosen Law

Heather Sellers*+
Legal Advocate
TAP Women's Resource Center

Pamela J. Gold*+
Domestic Violence Specialist
City of Roanoke Police Department

Evelyn Jordan, MSW*+
TAP Veterans' Program

David Bishop, NREMT-P
Battalion Chief
Roanoke City Fire and EMS

Kelsey Harrington
SARA Inc.

Corrine McKinney/Gwen Coleman+
Roanoke City Department of Social Services

Bill Duff+
Battalion Chief
Roanoke County Fire and EMS

Diane Kelly, BA
Executive Director
Mental Health America of RV

Sharon Jarrett Thacker
President and CEO
Family Service of Roanoke

Mike Early
Detective
Salem Police Department

Stacy Sheppard*+
Sergeant
Salem Police Department

Annette Pendleton
Program Director
Salem City Victim Witness Office

Jennifer Bath, MSN, AGCNS-BC*+
DVFR Co-Coordinator
Clinical Nurse Specialist
Trauma Services
Carilion Clinic-CRMH

Dr. Klaire Mundy, PsyD*
Psychologist

April McCadden
Sergeant, SVU
Roanoke Police Department

Lee Gouffray
Retired, Probation Supervisor
23rd Judicial District CSU

Dr. Keith Fender, PhD*+
Psychologist
Radford Counseling Group

Sue Goad
CPS Supervisor
Roanoke County DSS

Lois Fritz, MSN, RN
Forensic Nurse Examiner
Carilion Clinic-CRMH ED

Jill Sexton Lavinder
Director, Victim Witness
Roanoke CA Office

Dr. Isaac Van Patten, PhD*
Professor
Radford University
Criminal Justice Dept.

Matt Harris
Victim Witness
Roanoke County CA Office

Angela Hall
Radford Counseling Group

Stephen Daniel Poff
Chief Magistrate
23rd Judicial District, Region 2

Ashley Semones, BSN, RN
Forensic Nurse Examiner
Carilion Clinic-CRMH ED

Colleen French
Director
23-A District Court Service Unit

Brandon Hill
Detective
Vinton PD

Kaisha Williams, MS
Resident in Counseling
Sexual Violence Services Director
SARA, Inc.

Dr. Amy Tharp*
Assistant Chief Medical Examiner
Western Region-OCME

Diana Perkinson
Attorney
Perkinson Law

Sterling McLaughlin+
Program Manager
Family Service of Roanoke

Debbie Davidson, RN, SANE-A-P+
Forensic Nurse Examiner
Carilion Clinic-CRMH ED

Heather D. Smith, BSN, RN, C-NPT
Forensic Nurse Examiner
Carilion Clinic-CRMH ED

Frank Leftwich
Detective
Roanoke Police Department

Mike Weiss
Detective
Roanoke County PD

Tonia Drewery
Attorney
Legal Aid Services

About the Roanoke Valley

Roanoke, Virginia is an urban city located in the Western part of the state with a population of 98,465. Its borders touch the county of Roanoke, the city of Salem and the Town of Vinton, forming the Roanoke Valley. The Roanoke Valley has over 300,000 residents. Roanoke is the health-care, industrial, transportation and commercial center of western Virginia. The Roanoke Valley is the home of the Virginia Tech Carilion School of Medicine, Roanoke College, Hollins University, Jefferson College of Health Sciences and Virginia Western Community College.

Fatality Review Findings

Between **March 2010 and January 2014**, the Roanoke Valley Family and Intimate Partner Violence Fatality Review Team **reviewed 16** (**15 total cases with total of 15 offenders**) family and intimate partner (FIP) violence fatalities (homicides and homicide/suicides) that **occurred** in the **Roanoke Valley** from **1998 to 2012**. From **1999- 2013**, there were a **total of 99 FIP homicides with 91 separate fatal events** and an overall **rate of 3.1** in the Roanoke Valley (Roanoke County and the Cities of Roanoke and Salem) per the Virginia Department of Health (2015).

The following is a summary of findings:

- The **cases** were **classified** by type of incident based on the Virginia Department of Health's Family and Intimate Partner Homicide Surveillance Project[1]:

Types of Domestic Violence in Roanoke Valley, 1998-2012 (N=16)

Case Classification	Victims
Intimate Partner Homicide	12
Intimate Partner Associated Homicide	2
Child Homicide by Caregiver	1
Family Homicide, Other	1

Seven offenders (nearly 50%) completed or **attempted suicide** after the homicide, generally using the same weapon as used on the victim.

- **Gun**: **Five (all wounds were to the head)**.
- **Asphyxia: One** (at a later date).
- One offender attempted suicide and survived. Another offender contemplated suicide but did not complete a suicide.

The Role of Suicide in Domestic Violence
Homicides in Roanoke Valley, 1998-2012 (N=15)

Suicide Characteristic	Offenders
Offender Completed Suicide	6
Completed with a Firearm	5
Completed by Asphyxia	1
Attempted Suicide	1

[1] See definitions of these terms in the Glossary at the end of this report.

Suicide Characteristic	Offenders
Contemplated	1

- The **youngest victim** of family and intimate partner violence in the Roanoke Valley was **three** years old and the **oldest victim** was **83** years old with an **average age** of **47** years. The **youngest offender** was **14** years old and the **oldest offender** was **82** years old with an average age of **45.8** years.

- **12 victims** were **female** and **four** were **male**. **14 offenders** were **male** and **one offender** was **female**.

- **10 victims** were **Caucasian** and **six** were **Black or African-American**. **11 offenders** were **Caucasian** and **five** were **Black or African-American**.

Victims and Offenders in Roanoke Valley Family and Intimate Partner Deaths, Selected Characteristics, 1998-2012

Characteristic	Victims N=16	Offenders N=15
Age		
Range	3-83	14-82
Average	47	45.8
Gender		
Female	12	1
Male	4	14
Race		
Caucasian or White	10	11
Black or African American	6	5
Marital Status		
Married	9	4
Never Married	4	1
Divorced	2	1
Widowed	1	0
Unknown	0	9

- All **victims** were **killed in their own home**, or on the **property containing their home**.

- In addition to responding for the obvious homicide or homicide/suicide event, **law enforcement response in the Roanoke Valley involved** the following:
  - **Tactical team response** on **three** cases. One case required police negotiation for the offender to exit the home after the homicide.
  - **Two** law enforcement **officers** being **physically injured**.

- **One offender previously charged** with **assaulting** a law enforcement **officer**.
- **One offender** believed to have **committed suicide** while law enforcement was outside the residence.
- **One offender** was **shot** by **law enforcement** after committing homicide, and survived.
- **One case** involved the issuance of an **amber alert**.

Law Enforcement Involvement in Domestic Violence Homicides in the Roanoke Valley, 1998-2012 (N=15)

Law Enforcement Involvement	Cases
Tactical Team Response	3
Physical Injury of LE Officer	2
Police Negotiation Required	1
Offender Committed Suicide While LE Outside of Home	1
Offender Shot by LE After Committing Homicide	1
Amber Alert Issued	1
Offender Previously Charged with Assault on LE Officer	1

- **Children** or **eyewitnesses** were either **exposed or involved** during the fatal event including:
  - **One victim** was a **minor child**, although the **child's parent** is believed to have been the **main target**. **One offender** was a **minor child**.
  - **One event** occurred during a **child exchange** that ultimately involved two homicides.
  - **Five minor children** were either in **direct visual or hearing range** of the homicides during three fatal violence events.
  - **Two bystanders**, including one **child,** were **physically injured and survived an event**.
  - **Three cases** involved **eyewitnesses present** during the homicide. One case involved at least 12 eyewitnesses.

Children or Eyewitnesses Exposed or Involved in Fatal Domestic Violence Events in the Roanoke Valley, 1998-2012 (N=15)

Type of Exposure/Involvement	Cases
Minor Child	
Victim	1
Offender	1
Children in Direct Visual or Hearing Range During Fatal Event	5
Child Exchange	1
Bystanders Physically Injured During Event	
Child	1

Type of Exposure/Involvement	Cases
Adult	1
Cases with Eyewitnesses Present During Fatal Event	3

- At least **11 offenders** and **seven victims** were known to have **mental health issues** that included dementia, anger management issues or depression.

- At least **six offenders** and **five victims** were known to have a history of **alcohol/drug abuse.**

- **One victim** was **disabled**.

- **One offender** was an **illegal immigrant**.

Victim and Offender Characteristics, Domestic Violence Homicides in the Roanoke Valley, 1998-2012 (N=15)

	Cases
Mental Health Issues	
Victim	7
Offender	11
History of Alcohol/Drug Abuse	
Victim	5
Offender	6
Disabled	
Victim	1
Offender	0
Illegal Immigrant	
Victim	0
Offender	1

- **Five offenders** and **nine victims** sought **healthcare within the year** previous to the homicide or homicide/suicide for a variety of complaints, including trauma-related complaints.

- In **eight cases**, there were **prior 9-1-1 calls** by the **victim** for domestic violence by the offender.

- Six victims had been **involved with the legal system** prior to their death, either related to having been assaulted (three) or to obtain protective orders (three).

- In three cases, the offender either failed to appear in court (one) or the charges were dismissed (two).

- In **four cases**, **current POs were in place or waiting to be served** (one) at the victim's time of death, involving offender.

- **None** of the 16 **victims sought** the **services of a local domestic violence service provider.**

Interventions Sought by Victim and Offender in Domestic Violence Homicides in the Roanoke Valley, 1998-2012 (N=15)

Interventions	Cases
Healthcare Accessed within Last Year	
Victim	9
Offender	5
9-1-1 Calls by Victim for DV by Offender	8
Victim Involvement with Legal System Prior to Death	6
Assault	3
Obtain Protective Order	3
Protective Order Sought or In Place at Time of Homicide Involving Offender	4
Offender Involvement with Legal System Prior to Homicide	3
Charges Dismissed	2
Failure to Appear	1
DV Service Provider Accessed by Victim	0

- **10 offenders** were believed to have had some level of **forethought and planning** prior to the homicide.

- At least **three offenders** are known to have suffered **Adverse Childhood Experiences**, including one who as a child, came home to find his mother murdered by his father.

- At least **three offenders** were known to have **physically abused** their own **biological child**, prior to committing the homicide.

- **Two offenders** were charged with **assaulting a victim's current boyfriend** prior to committing homicide of the victim.

- At least **one offender** was known to have **physically abused an animal** prior to committing the homicide.

Offender Behaviors, Domestic Violence Homicides in the Roanoke Valley, 1998-2012 (N=15

Offender Behaviors	Cases
Forethought and Planning	10
Adverse Childhood Experiences	3
Prior Physical Abuse of Own Biologic Child	3
Assault on Victim's Current Boyfriend Prior to Homicide	2
Physical Abuse of an Animal	1

Red Flags/Risk Factors/Precipitating Factors/Other Issues were noted as follows:

- **11 offenders** were **unemployed** at the time of the homicide.
- **11 offenders** were experiencing **financial difficulties**.
- In **11 cases, family, friends or co-workers** were **aware of violence** by the offender toward the victim.
- **10 offenders** had **access to a gun**.
- **Two victims** were **attempting to leave** the relationship at the time of the homicide and **seven relationships had ended** at the time of the homicide.
- **At least seven of 15 cases** involved **death threats** by the offender toward the victim.
- **At least six of 15 cases** involved **stalking** by the offender.
- **At least five of 15 cases** involved the victim being previously **threatened with a weapon** by the offender.
- **At least two cases** involved the victim being **strangled** during the relationship by the offender.
- In **at least two cases**, a victim was believed to be either **sexually assaulted** or approached with **sexual** advances by the offenders prior to their deaths.

Risk Factors in Domestic Violence Homicides in the Roanoke Valley, 1998-2012 (N=15)

Risk Factor	Cases
Offender Unemployed at Time of Homicide	11
Offender Experiencing Financial Difficulties	11
Family, Friends, Co-workers Aware of Violence by Offender Toward the Victim	11
Offender had Access to a Gun	10
Victim Attempting to Leave Relationship (2) or Relationship Had Ended (7)	9
Offender Made Death Threats Toward Victim	7
Offender Stalked Victim	6
Offender Previously Threatened Victim with a Weapon	5
Offender Ever Strangled Victim During the Relationship	2
Offender Sexually Assaulted or Made Sexual Advances to Victim	2

- Six victims were tested for **drugs of abuse** [cocaine/benzoylecgonine (cocaine metabolite), phencyclidine (PCP), methamphetamine/MDMA (ecstasy), opiates (oxycodone, hydrocodone, morphine, oxymorphone, hydromorphone, heroin and 6-Acetylmorphine (heroin metabolite), methadone]. All were negative for drugs of abuse at the time of death. Nine victims were tested for **alcohol** with two positive for alcohol use (BAC range: 0.01% to 0.26%). For offenders completing a suicide, nine were not tested for **alcohol or drugs of abuse**. Three offenders were positive for **alcohol** (BAC range: 0.12% to 0.32%).

Drug or Alcohol Involvement in Domestic Violence Homicides in the Roanoke Valley, 1998-2012

Drug or Alcohol Involvement	Victim (N=16)	Offender (N=15)
Not Tested for Alcohol (completed suicides)	0	9
Tested for Drugs of Abuse	6	0
Tested for Alcohol	2	0
Positive for Drugs of Abuse	0	0
Positive for Alcohol	2	3

- **12 of 16 victim deaths** were the result of **gunshot wounds** followed by sharp-force (2), asphyxia (1), and undetermined (1).

Weapon Used to Committ Domestic Violence Homicide in the Roanoke Valley, 1998-2012 (N=16)

Weapon	Victims
Handgun	11
Rifle	1
Knife	2
Body Part	1
Unknown	1

- The **head/neck (10)** was the **body part most often involved** in all of the **homicides**, followed by the torso (seven) and extremities (four).

Victim Body Part(s) Involved in Domestic Violence Homicide in the Roanoke Valley, 1998-2012 (N=16)

Body Part	Victims
Head/Neck	10
Torso	7
Extremities	4

- **Nine offenders** were **not known to lawfully possess** the **firearm** used to commit the homicide:
  - One was a convicted felon. Another had a previous conviction of possession with intent to distribute 5 grams of cocaine.
  - Two offenders had active protective orders in place against them.
  - One offender was on unsupervised probation.
  - One offender was out on bond at time of homicide.
  - One offender made a verbal threat to professionals to kill prior to committing homicide and remained in possession of a weapon.
  - Two offenders were in possession of firearms previously confiscated, one for mental health issues and the other for unknown reasons.

Offenders Not Known to Legally Possess a Firearm at the Time of a Domestic Violence Homicide in the Roanoke Valley, 1998-2012 (N=9)

Reason for Firearm Prohibition	Cases
Active Protective Order in Place	2
Possession of Firearm Previously Confiscated	2
Convicted Felon	1
Previous Conviction of Possession with Intent to Distribute 5 grams of Cocaine	1
Unsupervised Probation	1
Out on Bond	1
Verbal Threat to Kill to Professionals Prior to Homicide and in Possession of Weapon	1

Other Information:

- **Two cases** were identified by the team as **mercy killings** *(the killing of someone who is very sick or injured in order to prevent any further suffering).*

- **None** of the **victims** had prior **military service**. **Three offenders** had prior **military service**.

- **Victim educational level** ranged from an **eighth grade education** to a **Master's Degree.**

- **One case** involved **custody issues** of a **pet**.

Family and Intimate Partner Violence Homicide Statistics (Local, State and National)

The Roanoke Valley

The Virginia Family and Intimate Partner Homicide (FIPH) Surveillance Project (VFIPHSP)[2] started tracking the number of victims of Family and Intimate Partner (FIP) Homicide in Virginia in 1999 and the issues surrounding these deaths. From 1999-2013, in the Roanoke Valley (Roanoke County and the Cities of Roanoke and Salem), there were 99 FIP homicides with an overall rate of 3.1 (VDH, 2015). Ninety-nine persons died in 91 separate fatal events in the Roanoke Valley from 1999-2013. Of these events:

- A child was present during the fatal event in 21 (23%) cases, with at least 32 children witnessing violence.
- 25 other persons were assaulted during the homicide event, but survived in 15 (16%) of the cases.
- More than one person was killed in 20 (22%) of the cases as well as:
    - Eight victims of multiple-homicide.
    - 19 (21%) cases in which the reported offender committed suicide (VDH, 2015).

The data represents violence that occurred in Virginia in which a victim was either injured or whose death was pronounced in the Roanoke Valley from 1999-2013. The data excludes one decedent who died in the Roanoke Valley, but whose injury occurred out of state. The data were taken from the Virginia Family and Intimate Partner (FIP) Homicide Surveillance Project. Rates are based on population data from the U.S. Census Bureau Annual Estimates for 1999-2013 and calculated per 100,000 persons. Statistics based on 20 or fewer cases are statistically unreliable and should be interpreted and used with caution (VDH, 2015). At the time of this report, 2014 data were unavailable.

[2] Virginia Department of Health, Office of the Chief Medical Examiner. http:www.vdh.virginia.gov/medExam/fipvhs-reports-publications.htm.

Number and Rate of Family and Intimate Partner Homicides in the Roanoke Valley by Year and Type, 1999-2013 (N=99)

Case Type	1999		2000		2001	
	No.	Rate	No.	Rate	No.	Rate
Intimate Partner Homicide (IPH)	4	1.9	3	1.5	3	1.4
Intimate Partner Associated Homicide (IPA)	0	0.0	0	0.0	1	0.5
Child Homicide by Caretaker (CHC)	0	0.0	0	0.0	1	2.2
Adult Homicide by Caretaker (AHC)	0	0.0	0	0.0	0	0.0
Other Family Homicide (OFH)	0	0.0	0	0.0	1	0.5
Family Associated Homicide (FAH)	0	0.0	0	0.0	0	0.0
Total	4	1.9	3	1.5	6	2.9

Type	2002		2003		2004		2005		2006		2007	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
IPH	1	0.5	2	1.0	2	1.0	6	2.9	3	1.4	1	0.5
IPA	2	1.0	4	1.9	2	1.0	2	1.0	2	1.0	3	1.4
CHC	0	0.0	0	0.0	0	0.0	1	2.2	2	4.4	0	0.0
AHC	1	0.6	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
OFH	0	0.0	0	0.0	1	0.5	2	1.0	0	0.0	0	0.0
FAH	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Total	4	1.9	6	2.9	5	2.4	11	5.3	7	3.3	4	1.9

Type	2008		2009		2010		2011		2012		2013		Total	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
IPH	3	1.4	3	1.4	5	2.3	3	1.4	3	1.4	4	1.8	46	1.5
IPA	5	2.3	0	0.0	2	0.9	1	0.5	2	0.9	0	0.0	26	0.8
CHC	4	8.8	3	6.5	2	4.3	2	4.4	1	2.2	0	0.0	16	2.3
AHC	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.0
OFH	0	0.0	0	0.0	3	1.4	0	0.0	0	0.0	1	0.5	8	0.3
FAH	1	0.5	1	0.5	0	0.0	0	0.0	0	0.0	0	0.0	2	0.1
Total	13	6.1	7	3.3	12	5.6	6	2.8	6	2.8	5	2.3	99	3.1

Virginia-Domestic Violence Fatalities Family and Intimate Partner Homicide in Virginia, 2007-2012

- On average, domestic violence fatalities account for one-third of all homicides in the state of Virginia.

Virginia-Suicides with Co-Occurring Violence and IPV Problems[3]

- From 2003-2012, ***in Virginia***, there were 9,154 total suicides with co-occurring violence and/or intimate partner problems. Of these suicides:
  - 235 (2.6%) committed homicide prior to the suicide.
  - 72 (0.8%) attempted homicide prior to the suicide.
  - 576 (6.3%) perpetrated fatal or non-fatal violence against another person in the past month.
  - 58 (0.6%) were the victim of violence in the past month.
  - **3,004 (32.8%) were having conflict (may or may not have been violent in nature) with an intimate partner at the time of the suicide** (VVDRS, 2015).

Suicides in Virginia with Co-Occurring Violence and/or Intimate Partner Problems: 2003-2012[3]

Year	Total Suicides	Committed Homicide Prior to the Suicide[2]		Attempted Homicide Prior to the Suicide[3]		Perpetrator of Violence, Past Month[4]		Victim of Violence, Past Month[5]		Intimate Partner Problems[6]	
	No.	No.	%	No.	%	No.	%	No.	%	No.	%
2003	796	15	1.9	4	0.5	38	4.8	5	0.6	233	29.3
2004	818	21	2.6	9	1.1	57	7.0	4	0.5	234	28.6
2005	857	24	2.8	7	0.8	65	7.6	12	1.4	291	34.0
2006	872	22	2.5	8	0.9	54	6.2	6	0.7	299	34.3
2007	867	20	2.3	4	0.5	48	5.5	3	0.3	280	32.3
2008	936	28	3.0	9	1.0	65	6.9	7	0.7	339	36.2

[3] Virginia Department of Health, Office of the Chief Medical Examiner, Virginia Violent Death Reporting System (VVDRS). http://vdh.virginia.gov/medExam/NDVRS.htm

Year	Total Suicides	Committed Homicide Prior to the Suicide[2]		Attempted Homicide Prior to the Suicide[3]		Perpetrator of Violence, Past Month[4]		Victim of Violence, Past Month[5]		Intimate Partner Problems[6]	
2009	956	29	3.0	10	1.0	74	7.7	2	0.2	347	36.3
2010	980	32	3.3	9	0.9	67	6.8	7	0.7	327	33.4
2011	1,036	24	2.3	6	0.6	63	6.1	9	0.9	323	31.2
2012	1,036	20	1.9	6	0.6	45	4.3	3	0.3	331	31.9
TOTAL	**9,154**	**235**	**2.6**	**72**	**0.8**	**576**	**6.3**	**58**	**0.6**	**3,004**	**32.8**

[1] Classifications are not mutually exclusive. For example, a single suicide decedent may have committed homicide prior to the suicide, been a victim of violence in the past month, and also had an intimate partner problem.
[2]Suicide decedents who committed homicide prior to their suicide. The person(s) killed may or may not have been intimate partners or family members.
[3] Suicide decedents who attempted to commit homicide prior to their suicide. The person(s) they attempted to kill may or may not have been intimate partners or family members.
[4]Suicide decedents who perpetrated fatal or non-fatal physical violence against another person in the past month. The person the violence was perpetrated against may or may not have been an intimate partner or family member.
[5]Suicide decedents who were victims of non-fatal physical violence in the past month. The person who committed the violence against the decedent may or may not have been an intimate partner or family member.
[6]Suicide decedents having conflict with an intimate partner at the time of the suicide. The conflict may or may not have been violent in nature.

Western OCME Region-Suicides with Co-Occurring Violence and IPV Problems[4]

- From 2003-2012, in the ***Western OCME Region***, there were 2,552 total suicides with co-occurring violence and/or intimate partner problems. Of these suicides:
  - 75 (2.9%) committed homicide prior to the suicide.
  - 19 (0.7%) attempted homicide prior to the suicide.
  - 179 (7.0%) perpetrated fatal or non-fatal violence against another person in the past month.
  - 21 (0.8%) were the victim of violence in the past month.
  - **828 (32.4%) were having conflict (may or may not have been violent in nature) with an intimate partner at the time of the suicide** (VVDRS, 2015).

[4] Ibid.

Year	Total Suicides	Committed Homicide Prior to the Suicide[2]		Attempted Homicide Prior to the Suicide[3]		Perpetrator of Violence, Past Month[4]		Victim of Violence, Past Month[5]		Intimate Partner Problems[6]	
	No.	No.	%	No.	%	No.	%	No.	%	No.	%
2003	221	5	2.3	2	0.9	9	4.1	0	0.0	64	29.0
2004	241	7	2.9	2	0.8	24	10.0	3	1.2	81	33.6
2005	264	12	4.5	2	0.8	24	9.1	6	2.3	90	34.1
2006	241	4	1.7	1	0.4	11	4.6	0	0.0	84	34.9
2007	254	7	2.8	1	0.4	13	5.1	0	0.0	67	26.4
2008	257	8	3.1	3	1.2	21	8.2	0	0.0	81	31.5
2009	257	9	3.5	2	0.8	22	8.6	1	0.4	97	37.7
2010	267	11	4.1	2	0.7	21	7.9	4	1.5	84	31.5
2011	288	9	3.1	1	0.3	19	6.6	5	1.7	85	29.5
2012	262	3	1.1	3	1.1.	15	5.7	2	0.8	95	36.3
TOTAL	**2,552**	**75**	**2.9**	**19**	**0.7**	**179**	**7.0**	**21**	**0.8**	**828**	**32.4**

[1] Classifications are not mutually exclusive. For example, a single suicide decedent may have committed homicide prior to the suicide, been a victim of violence in the past month, and also had an intimate partner problem.
[2]Suicide decedents who committed homicide prior to their suicide. The person(s) killed may or may not have been intimate partners or family members.
[3] Suicide decedents who attempted to commit homicide prior to their suicide. The person(s) they attempted to kill may or may not have been intimate partners or family members.
[4]Suicide decedents who perpetrated fatal or non-fatal physical violence against another person in the past month. The person the violence was perpetrated against may or may not have been an intimate partner or family member.
[5]Suicide decedents who were victims of non-fatal physical violence in the past month. The person who committed the violence against the decedent may or may not have been an intimate partner or family member.
[6]Suicide decedents having conflict with an intimate partner at the time of the suicide. The conflict may or may not have been violent in nature.

National Domestic Violence Related Statistics

- More than 12 million men and women are the victims of intimate partner violence (IPV) each year in the U.S. (CDC, 2014).

- In 2007, IPV resulted in 2,340 deaths (14% of all homicides). Of these homicides, 30% were males and 70% were females (CDC, 2014).

- On average, greater than three women are murdered each day by their boyfriends or husbands in the U.S. (FWV, 2015).

- Each year in the U.S., 7.5 million people are stalked (SRC, 2015).

- 76% of women killed by their intimates were stalked (McFarlane et al., 1999).

- 89% of victims of intimate partner femicide who had been physically assaulted had also been stalked in the 12 months prior to their murder (SRC, 2015).

- 15.5 million U.S. children reside in families in which IPV occurred at least once in the previous year and seven million children reside in families where severe IPV occurred (FWV, 2015).

- 4% of abused females utilized a domestic violence shelter or hotline in the year prior to being killed by an IP (Sharps et al., 2001 as cited in MNADV, 2014).

- 1/3rd of women murdered in U.S. workplaces, between 2003-2008- were killed by a current or former IP (NDVH, 2015).

- The leading cause of death in the U.S. among African-American females from 15-45 years of age and the seventh leading cause of premature death in women overall is femicide (Greenfield, Rand & Craven, 1998 as cited in Campbell et al., 2003).

- 67-80% of intimate partner homicides involve physical abuse of the female by the male partner before the murder occurs; no matter which partner is killed (Greenfield, Rand, & Craven (1998); Mercy & Saltzman (1989); Langford, Isaac, & Kabat (1998); Campbell (1992); McFarlane, Campbell, Wilt, Sachs, Ulrich, & Xu (1999) and Pataki (1997) as cited in Campbell et al., 2003).

- In the Campbell et al., 2003* study-
    - Pre-incident risk factors associated with increased risk of intimate partner femicide include the perpetrator having access to a gun (greater than five-fold increase when considering other factors of abuse) and previous threat with a weapon, stepchild of

the perpetrator living in the home and estrangement, particularly from a controlling partner.
    - Significant incident factors included the victim having left the relationship for another partner and the perpetrator's use of a gun.
    - Stalking, forced sex and abuse during pregnancy were identified as significant bivariate- level risks.

- 83% of perpetrators, victims or both had interaction with the criminal justice system, victim assistance and/or healthcare facility in the year prior to the homicide (Campbell et al., 2007).

- Greater than 44% of abusers were arrested, and close to one-third of victims called the police in the year prior to the homicide (Sharps et al., 2001 as cited in MNADV, 2014).

- Unemployed abusers were found to have a four-fold increased risk of femicide, as compared to employed abusers in the Campbell et al. (2003) study.

- The presence of a gun in the home raises the risk of homicide 20 times when there is a history of domestic violence (Johns Hopkins Center for Gun Policy and Research, 2010 as cited in NCADV, n.d.).

- The most common type of murder-suicide involves two intimate partners with the man killing his girlfriend or wife (VPC, 2012).

- 25% of murder-suicides were committed by a person 55 years of age or older in which declining health of the offender, victim or both is an issue (VPC, 2012).

- Common contributing factors in murder-suicide in the older adult population include stress of caring for a spouse in ill health and depression (Malphurs & Cohen, 2005).

- 25-50% of women receiving victim services for IPV have substance abuse problems (Bennett & Lawson, 1994; Downs, 2001; Ogle & Baer, 2003 as cited in VAWA, 2011).

- 55-99% of women with substance abuse issues have been victimized some time during their life (Moses et al., 2003 as cited in VAWA, 2011).

- Greater than half of all femicide involved alcohol and drug use by the offender (Fagan, 1993 as cited in Sharps et al., 2003).

- 40-45% of women in an abusive relationship will be sexually assaulted at some time during the relationship (Tjaden & Thoennes, 2000).

- 47-68% of women evaluated for intimate partner violence (IPV) report being strangled (Stapczynski, 2010).

Recommendations

The following recommendations are based on careful analysis of the data and Team findings, and on current best practices. The Team is comprised of professionals in the fields of law enforcement, healthcare, community service providers, court and probation, domestic violence shelter representatives, family services, social services, medical examiner, mental health providers, offender services providers, prosecutors and system-based victim services and others as appropriate to the case. The recommendations are written to further strengthen practice by developing a better understanding of how and why violence happens, to try to reduce future deaths or disabilities and to respond appropriately to victims and offenders.

Furthermore, the recommendations were developed based on the World Health Organization (WHO) (2014) and its partners' violence prevention strategies and response effort that include the following:

- developing safe, stable and nurturing relationships between children and their caregivers;
- developing life skills in the pediatric population;
- decreasing the availability and harmful use of alcohol;
- decreasing access to guns and knives;
- encouraging gender equality to prevent violence against women;
- altering cultural and social norms that support violence, and
- identifying victims and providing care and support programs.

Recommendation One

Recommendation #1:
Employ universal screening for abuse within all healthcare facilities within the Roanoke Valley at routine visits and for any injury related visit.

Supporting Data from Team Reviews:
- Five offenders and nine victims sought healthcare within the year previous to the homicide or homicide/suicide for a variety of complaints, including trauma related complaints.
- **None** of the 15 **victims sought** the **services of a local domestic violence service provider.**
- At least **11 offenders** and **seven victims** were known to have **mental health issues** that included dementia, anger issues or depression.

Supporting Evidence and Brief Description:

Intimate Partner Violence (IPV) is a significant, yet preventable public health problem. It is a pattern of coercive and assaultive behaviors to gain power, and control over a current or former partner. According to the CDC (2014), more than 12 million men and women are the victims of intimate partner violence (IPV) each year in the U.S. In 2007, IPV resulted in 2,340 deaths (14% of all homicides) in the U.S. Of these victims, 30% were male and 70% were female (CDC, 2014).

On average, more than three women are murdered each day by their boyfriends, ex-boyfriends, husbands or ex-husbands in the U.S. (FWV, 2015). The costs of IP violence is estimated at 8.3 billion yearly in medical, dental, legal services and lost productivity.

Healthcare providers are in a unique position to recognize, assist, intervene and connect victims of violence to resources. Any female presenting to an emergency department (ED) with a complaint of trauma should be considered abused until abuse can be ruled out. Abused

women often seek care in EDs, but are not screened for IPV, how they sustained the injury or asked if someone else caused their injury. Nearly half, 44%, of women killed by intimate partners had sought help in an ED in the two years preceding their death (Wadman & Muelleman, 1999).

"The Society for Academic Emergency Medicine reports that, upon a review of emergency department visits, domestic violence is found in: 25% of women who attempt suicide, 50% of mothers of abused children, 58% of female rape victims over the age of 30, 15% of visits to emergency departments by women, 25% of all women seeking emergency department treatment for physical injuries, and 25% of women using an emergency psychiatric service" (PROJECT RADAR Emergency Medicine Module, 2012).

Position statements for universal screening for IPV in the medical community have been published by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Emergency Nurses Association, and the American Medical Association. Under Joint Commission of Care, PC.01.02.09, JCAHO mandates that possible victims of abuse be identified using criteria developed by the hospital; be assessed, or referred for assessment, and that possible cases of abuse and neglect be reported both internally and externally (as appropriate).

Plan:

Implement universal screening for intimate partner violence in local hospitals and medical offices for all patients as appropriate, based on current national recommendations and standards of care.

Recommendation Two

Recommendation #2:
Employ use of Lethality Assessment Tool within all Roanoke Valley law enforcement jurisdictions and among court services intake officers.

Supporting Data from Team Review:

- **Five of 15 cases involved the victim reporting being threatened with a weapon by the offender.**
  (LAP question- Has he/she ever used a weapon against you or threatened you with a weapon?)

- **Seven of 15 cases involved death threats by the offender toward the victim.**
  (LAP question-Has he/she threatened to kill you or your children?)

- **Two victims expressed fear that their former intimate partner may kill them, one on the day of her homicide. Two other family members expressed concerned that their family member may commit homicide in two other cases.**
  (LAP question- Do you think he/she might try to kill you?)

- **Two cases involved the victim reporting being strangled during the relationship by the offender.**
  (LAP question- Has he/she ever tried to choke you?)

- **Two victims were attempting to leave the relationship at the time of the homicide. Seven relationships had ended at the time of the homicide.**
  (LAP question- Have you left him/her or separated after living together or being married?)

- **11 of offenders were unemployed at the time of the homicide.**
  (LAP question- Is he/she unemployed?)

- **Out of 15 cases, six offenders completed a suicide:**
  (LAP question- Has he/she ever tried to kill himself/herself?)

- **Six of 15 cases involved stalking by the offender.**
  (LAP question- Does he/she follow or spy on you or leave you threatening messages)

- In **two cases**, a victim was believed to be either, **sexually assaulted** or approached with **sexual** advances by the offenders prior to their deaths.
  (Not a LAP question, but is included on Dr. J. Campbell's Danger Assessment that the LAP is modeled after).

Supporting Evidence and Brief Description:

There are 1,500 domestic violence homicides a year in the U.S., not including collateral deaths such as domestic violence suicides and drug-related deaths. For every one domestic violence homicide, there are eight to nine near homicides (attempt to kill by shooting, stabbing, severe assault).

Intimate partner homicide is predictable and preventable. Lethality assessment is used to identify and educate victims in regard to risk factors associated with intimate partner homicide and to encourage them to seek domestic violence services. Campbell's Danger Assessment was developed in 1986. The Lethality Assessment Program-the Maryland Model was developed in 2005 by the Maryland Network Against Domestic Violence (MNADV), modeled after the Danger Assessment. One-hundred percent of Maryland police agencies are now utilizing the LAP (MNADV, 2014). The LAP is being used or implemented in 30 U.S. states (MNADV, 2014). Local jurisdictions in Virginia that are utilizing the LAP include: Roanoke County, the Town of Vinton and the City of Norfolk.

The state of Maryland saw a 34% decrease in IP DV homicides from July 2007 to June 2012, at least partially attributed to the use of the Maryland Model LAP (VDCJS, 2013). Anecdotally, programs using the LAP report fewer DV-related repeat calls for service and victims more willing to cooperate and speak with DV advocates (VDCJS, 2013). Publication of a NIJ study in Oklahoma looking at specific outcome of lethality assessment is pending (VDCJS, 2013).

Lethality assessment is introduced to the victim by the responding officer who screens for homicide risk. It is introduced simply, privately and positively. Scoring is not only based on response by the victim, but also at the discretion of the officer when there is high risk, even when a victim may minimize or deny severity. Once screened, the officer advises the victim of danger, calls the local domestic violence hot-line and encourages the victim to speak with the hot-line call-taker. If the victim does not agree to seek immediate safe shelter referral, the DV program will follow-up with the victim 24 hours after the initial call.

Future development of a plan to review high-risk IPV cases should be considered to assist in further reducing IPV homicide. Since implementation of a high-risk review (extreme danger per Danger Assessment) by the Greater Newburyport (Massachusetts) Domestic Violence High Risk Team, there have been zero homicides in the communities participating in the project. 129 high-risk cases were identified by the team. Prior to the implementation of the team, there were eight DV related deaths over a ten-year period. The team reports few victim re-assaults, increase in victims accessing DV services and less victims needing to seek safe shelter outside of their home. The team also reports an increase in the number of offenders who were detained pre-trial, a decrease in dismissal rate, and an increase in offenders found guilty and sentenced to jail (JGCC, 2013).

Plan:
Implement the LAP (see LAP) or Dr. Campbell's Danger Assessment (see assessment).

Develop high-risk review team for IPV cases.

Recommendation Three

Recommendation #3:
Develop unified community response to intimate partner homicides to assist survivors through the immediate crisis and recovery phases.

Supporting Data from Team Review:

- In Roanoke Valley cases from 1999-2013, there were 21 out of 99 (23%) cases in which a child was present during the fatal assault, totaling at least 32 children exposed to violence (VDH, 2015).

- At least three offenders of the 15 cases in this series (20%) are reported to have suffered Adverse Childhood Experiences, including one who came home to find his mother murdered by his father when he was a child.

- At least three offenders (20%) were known to have physically abused their own biologic child prior to committing the homicide.

- Two bystanders, including one minor child, were physically injured and survived.

- Three cases involved eyewitnesses present during the homicide. One event was witnessed by 12 people.

- In 11 cases, family, friends or co-workers were aware of violence by the offender toward the victim.

Supporting Evidence and Brief Description:

While domestic violence fatalities have clear primary victims, there are many peripheral victims that are often forgotten during the initial response by law enforcement and other agencies involved. 15.5 million U.S. children reside in families in which intimate-partner violence occurred at least once in the previous year and seven million children reside in families where severe intimate partner violence occurred (FWV, 2015).Through case review, it is clear that children of domestic abuse grew up to become abusers themselves. Children and adult

family members and friends that survive the terminal event suffer significant psychological as well as possible physical trauma and would benefit from additional resources and assistance to prevent future events.

Plan:

Develop a multi-jurisdictional, multidisciplinary "Emergency Response Team" in the Roanoke Valley that would respond as soon as possible to incidents of family/domestic violence in which a death has occurred. This team may include (but is not limited to) members of social services, law enforcement, spiritual leaders, child advocates and health care professionals including psychotherapists/psychiatric professionals. Members would be expected to be deployed as appropriate for the specific event and would have specialized training in dealing with all the issues that are applicable to domestic/family violence. The response team would be proactive in assisting survivors of these events in obtaining the assistance they need, access to resources and maintaining close contact and a positive relationship with these individuals. This team's assistance to families, children and friends would be beneficial not only to survivors (to help prevent future events by breaking the cycle of violence) but, also to law enforcement by providing an open line of communication to these individuals who may have information needed for the investigation.

Recommendation Four

Recommendation #4:
Develop a community intimate partner violence education campaign in the Roanoke Valley to include warning signs of homicide, changing the culture, "reasons the victims stay," economic costs, the effects on children, and available services.

Supporting Data from Team Review:
- At least 11 offenders and seven victims were known to have mental health issues that included dementia, anger issues or depression.
- At least six offenders and five victims were known to have a history of alcohol/drug abuse.
- For offenders completing a suicide, nine were not tested for alcohol or drugs of abuse. Three offenders were positive for alcohol (BAC range: 0.12% to 0.32%).
- 10 offenders were believed to have had some level of forethought and planning prior to the homicide.
- Five offenders and nine victims sought healthcare within the year previous to the homicide or homicide/suicide for a variety of complaints, including trauma related complaints.
- Six victims had been involved with the legal system prior to their death, either related to having been assaulted (three) or to obtain protective orders (three).
    - In three cases, the offender either failed to appear in court (one) or the charges were dismissed (two).
- 11 offenders were experiencing financial difficulties.
- In 11 cases, family, friends or co-workers were aware of violence by the offender toward the victim.
- At least seven of 15 cases involved death threats by the offender toward the victim.
- **None** of the 15 **victims sought** the **services of a local domestic violence service provider.**

Supporting Evidence and Brief Description:
Domestic violence fatalities have included not only victims and offenders, but also children and community members who have been impacted by the violence. The evidence suggests that not only was there an awareness of violence by friends, family, and community, but many of the

victims were not linked to services. Legal support was limited at times. Methodical case review has reflected several loop holes in community support. In cases where children are involved:

- 50% of children living with a batterer become involved in the physical assault (i.e. calling for help, yelling, physically intervening).

- Children exposed to IPV/DV show a higher rate of symptoms if they are physically abused by either parent.

- Batterers are several times more likely to physically abuse children than non-batterers.

- Study of 6000 subjects found that 49% of batterers physically abused children whereas 7% of non-batterers men do so.

- Exposure to battering increases risk for poor concentration, restlessness, trouble sleeping alone, night-mares, oppositional defiant disorder, depression, aggression with peers, increased suspension, involvement with the juvenile justice system and becoming a violent offender (Bancroft, Silverman & Ritchie, 2012).

Plan:

Develop an educational campaign comprised of mental health professionals, healthcare providers and law enforcement personnel that is designed to assist with a list of potential warning signs as identified within the data (i.e. legal history, history of violence, substance/alcohol abuse history, etc.). The educational campaign will include the following:

- ***Development of a Domestic Violence First Aid*** plan that will allow for consistent community response to assist with decreased potential for injury and/or lethality. The plan will consist of training community responders and implementing 4 major components:
    - *Signs of Domestic Violence and Trauma Response*
    - *Impact of Domestic Violence – Reasons Why Victims Stay, Effects on Children*
    - *5 Step Action Plan to Assess a Situation:*
        - Assess risk of homicide, suicide and harm.
        - Listen nonjudgmentally.
        - Give assurance and information.
            - It is also imperative that those who have contact/interaction with victims (especially healthcare providers, magistrates,

police, workplaces, etc.) be provided with education on ways to provide information without placing the victim in danger.
        - Additional education should be provided in other community venues (i.e. school officials, clerics, etc.) that may have interaction with the victims in a community-based setting.
            - Educational support within the community would potentially decrease the need for emergency responses (both medically and legally) and increase the potential for the victim to engage in independent stability, thereby decreasing social support.
    - Link victims and families to appropriate professional help.
        - Educate emergency departments, physicians' offices, healthcare settings, mental health service providers of best practices and interventions that would be provided to resources and connections to potential victims of DV/IPV and/or their children.
        - Encourage employers to adopt DV Free Zone model policies (Legal Momentum's- "This Workplace is a DV-Free Zone").
    - Encourage self-help and other support strategies.
- ***Local Resources*** *and Where to Turn for Help including public awareness campaign that would include signs of domestic violence and local agencies assisting victims and offenders of violence to include* ***PSAs and advertising via local media, buses, and billboards****.*

Other considerations in implementing a DV First Aid type response in the community include the following:

- Development of standards and a certificate program that would regulate and promote effective practice of DV/IPV intervention programs.

- Development of subcommittee linked to the courts which will make referrals to certified intervention programs within the community.

- Develop an advanced certification program/process for law enforcement and others serving as first responders in DV/IPV situations.

- Comprehensive assessment of services that will be provisioned that will include assessing the actual level of service capacity with the actual need as supported by criminal justice, community and public health data.

- All funding allocations should be assessed to determine effectiveness of each region's coordinated community response and its relationship to incidence of domestic violence and homicide rates.

- Ongoing evaluation and assessment of public health data to be collected and evaluated which would result in potential correlations with other health risk factors when victims are seeking medical services in the healthcare system.

- Implementation of trained DV professionals to be present in court to provide victim assistance and court education during legal proceedings.

In order to implement this plan, **develop a Coordinated Community Response (CCR)** (information from thedeluthmodel.org) that includes:

- Written policies for practitioners that provide centralized victim safety and offender accountability and a coordinated interagency intervention strategy

- Protocols and procedures to link agencies and disciplines

- An independent agency to track and monitor cases and assess data

- An interagency process that develops a strategic plan with practitioners working together to resolve problems

- A process that allows for coordinated focus on systemic problems of an organization between criminal and civil justice agencies, community members, and victims to close gaps and improve the community's response to battering and IPV

- A central role for advocates and victims in defining and evaluating interagency intervention

- A commitment to support each other's attempts to secure adequate resources to respond to these cases.

For children exposed to DV in the home:

- **Include Healthy Relationships program in all educational facilities** beginning in elementary school.
    - **Implement and hire coordinator/educator in public schools to provide Healthy Relationships education program. The coordinator/educator could also facilitate the CCR team, DVF review and emergency response teams.**

- Explore schools that have trauma-informed teaching models to help students with decreased punitive responses during times of acting out behaviors.
    - Support and encourage schools to participate in a healthy relationship program.

- Support an increase in awareness of services for children within the community (i.e. Forgotten Victim's Program).

Glossary

Adult Homicide by Caretaker (AHC): A homicide in which a victim was a dependent adult 18 years or older who was killed by a caretaker. A dependent adult could include someone who is elderly or disabled, and requires part- or full-time care from another person.

Alleged offender: A person who law enforcement suspects or charges with the commission of a homicide.

Caregiver: A person responsible for the care and/or supervision of another person.

Child Homicide by Caregiver (CHC): A homicide in which a victim was a child under the age of 18 killed by a caregiver.

Family Associated Homicide (FAH): A homicide in which a victim was killed as a result of violence stemming from a family relationship. Victims could include alleged abusers killed by law enforcement or persons caught in the crossfire of family violence such as friends, co-workers, neighbors, relatives, intimate partners, or bystanders.

Family Homicide, Other (OFH): A homicide in which a victim was killed by an individual related to them biologically or by marriage with the exception of spouses (e.g. grandparent, [step] parent, [step] sibling, cousin, in-law).

Intimate Partner Associated (IPA) Homicide: A homicide in which a victim was killed as a result of violence stemming from an intimate partner relationship. Victims could include alleged abusers killed by law enforcement or persons caught in the crossfire of intimate partner violence such as friends, co–workers, neighbors, relatives, new intimate partners, or bystanders.

Intimate Partner (IPH) Homicide: A homicide in which a victim was killed by one of the following: spouse (married or separated), former spouse, current or former boyfriend, girlfriend or same–sex partner, or dating partner. This group could include homicides in which only one of the parties had pursued a relationship or perceived a relationship with the other, as in some stalking cases (VDH, 2015).

References

Bennett, L. & Bland, P. (2011). Substance abuse and intimate partner violence. Retrieved December 15, 2015, from http://www.vawnet.org/applied-research-papers/print-document.php?doc_id=1324

Campbell, J., Glass, N., Sharps, P. W., Laughon, K., & Bloom, T. (2007). Intimate partner homicide: Review and implications of research and policy. *Trauma, Violence & Abuse*, *8*(3), 246-69.

Campbell, J.C. Webster, D., Koziol-McLain, J. et.al. (2003). Risk Factors for Femicide in Abusive Relationships: Results from a Multi-Site Case Control Study. *American Journal of Public Health, 93* (7), 1089-1097.

Campbell, J. (2002). Health consequences of intimate partner violence. *THE LANCET, 359*, 1331-36.

Campbell, D. W., Sharps, P. W., Gary, F., Campbell, J. C., & Lopez, L. M. (2002). Intimate partner violence in African American Women. Online Journal of Issues in Nursing, 7(1). Retrieved January 9, 2016, from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume72002/No1Jan2002/AfricanAmericanWomenPartnerViolence.html

Centers for Disease Control and Prevention (CDC). (2014). Understanding intimate partner violence. Retrieved March 8, 2015, from http://www.cdc.gov/violenceprevention/pdf/ipv-factsheet.pdf

Centers for Disease Control and Prevention (CDC) Injury Prevention and Control: Division of Violence Prevention. (2014). CDC helps prevent global violence. Retrieved March 8, 2015, from http://www.cdc.gov/violenceprevention/globalviolence/index.html

de Boinville, M. (2013). APSE policy brief: Screening for domestic violence in healthcare settings. Retrieved April 28, 2015, from http://aspe.hhs.gov/hsp/13/dv/pb_screeningDomestic.cfm

Domestic Abuse Intervention Programs. (2011). Coordinated Community Response (CCR). Retrieved December 15, 2015, from http://www.theduluthmodel.org/change/community-response.html

Felitti, V. J., Anda, R., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: Adverse childhood experiences study. *American Journal of Preventive Medicine, 14*(4), 245-258.

Futures Without Violence. (2015). Get the facts. Retrieved March 8, 2015, from http://www.futureswithoutviolence.org/resources-events/get-the-facts/

Jeanne Geiger Crisis Center. (2013). Greater Newburyport domestic violence high risk team: Safety and accountability report, 2005-2013. Retrieved March 8, 2015, from http://dvhrt.org/assets/resources/Safety_Accountability_Report_2005_2013.pdf

Joint Commission. (2015). Comprehensive accreditation manual for hospitals: Provision of care chapter. Retrieved March 28, 2015, from http://www.jointcommission.org/

Koziol-McLain, J., Webster, D., McFarlane, J., Block, C. R., Ulrich, Y., Glass, N., & Campbell, J. C. (2006). Risk factors for femicide-suicide in abusive relationships: Results from a multisite case control study. *Violence Vict, 21*(1), 3-21.

Malphurs, J. E., & Cohen, D. (2005). A statewide case-control study of spousal homicide-suicide in older persons. *American Journal of Geriatric Psychiatry 13*(3), 211-7.

Maryland Network Against Domestic Violence (MNADV). (2014). Revised statistics information. Retrieved March 8, 2015, from http://mnadv.org/_mnadvWeb/wpcontent/uploads/2014/10/LAP-Public-Stats-Memo.pdf

McFarlane, J. M., Campbell, J., Wilt, S., Sachs, C. J., Ulrich, Y., & Xu, X. (1999). Stalking and intimate partner femicide. *Homicide Studies, 3*(4), 300-316.

Messing, J. T., Campbell, J., Wilson, J. S., Brown, S., Patchell, B., & Shall, C. (2014). Police departments' use of the lethality assessment program: A quasi-experimental evaluation: Final report (submitted to U. S. Department of Justice. (2014).

National Coalition Against Domestic Violence (NCADV). (n.d.). Domestic violence and guns. Retrieved March 8, 2015, from http://www.ncadv.org/images/Gun_Fact_Sheet.pdf

National Domestic Violence Hotline. (2015). Get the facts and figures. Retrieved March 8, 2015, from http://www.thehotline.org/resources/statistics/

Office on Women's Health (OWH). (2012). Health care providers and screening and counseling for interpersonal and domestic violence. Retrieved April 28, 2015, from http://www.womenshealth.gov/publications/ourpublications/factsheet/IPV_screening_508.pdf

Rabin, R. F., Jennings, J. M., Campbell, J. C., Bair-Merritt, M. H. (2009). Intimate partner violence screening. *American Journal Preventive Medicine, 36*(5), 439-445.

Sharps, P., Campbell, J. C., Campbell, D., Gary, F., & Webster, D. (2003). Risky mix: Drinking, drug use and homicide. *NIJ Journal, 250*, 9-13.

Sharps, P., Koziol-McLain, J., Campbell, J., McFarlane, J., Sachs, C., & Xu, Z. (2001). Health care providers missed opportunities for preventing femicide. *Preventive Medicine, 33*(5), 373-380.

Sprague, S., Madden, K., Simunovic, N., Godin, K., Pham, N. K., Bhandari, M., & Goslings, J. C. (2012). Barriers to screening for intimate partner violence. *Women Health, 52*(6), 587-605.

Stalking Resource Center (SRC). (2015). Stalking fact sheet. Retrieved March 8, 2015, from http://www.victimsofcrime.org/docs/default-source/src/stalking-fact-sheet-2015_eng.pdf?sfvrsn=2

Stapczynski, J. S. (2010). Strangulation injuries. *Emergency Medicine Reports*, *31*(17), 1-10.

Tjaden, P., & Thoennes, N. (2000). Extent, nature and consequences of intimate partner violence. Retrieved January 9, 2016, from https://www.ncjrs.gov/pdffiles1/nij/181867.pdf

United States Census Bureau. (2015). Quick facts from the US census bureau. Retrieved January 13, 2015, from http://quickfacts.census.gov/qfd/states/51/51161.html

Violence Policy Center (2012). American roulette: Murder-suicide in the United States (4th ed.). Retrieved January 9, 2016, from http://www.vpc.org/studies/amroul2012.pdf

Virginia Department of Criminal Justice Services (VDCJS). Review of lethality assessment programs (LAP). (2013). Retrieved February 27, 2015, from http://www.dcjs.virginia.gov/research/documents/Lethality_Assess_Report_FINAL.pdf

Virginia Department of Health (VDH) Office of the Chief Medical Examiner. (2015). Virginia family and intimate partner homicide surveillance project. Retrieved March 2, 2015, from http://www.vdh.gov/medExam/familyintimatepartnerviolencehomicidesurveillace.htm

Virginia Violent Death Reporting System (VVDRS), Office of the Chief Medical Examiner, Virginia Department of Health. (2014). A National Violent Death Reporting System project. Retrieved March 3, 2015, from http://www.vdh.virginia.gov/medExam/NVDRS.htm

Virginia Department of Health (VDH) Office of the Chief Medical Examiner. Family and intimate partner violence: Fatality review team protocol (2nd ed.). Retrieved March 2, 2015, from http://www.vdh.state.va.us/medExam/documents/protocol2.pdf

Waalen, J., Goodwin, M. M., Spitz, A. M., Petersen, R., Saltzman, L. E. (2000). Screening for intimate partner violence. *American Journal of Preventive Medicine, 19*(4), 230-237.

Wadman, M. C., & Muelleman, R. L. (1999). Domestic violence homicides: ED use before victimization. *The American Journal of Emergency Medicine, 17*(7), 689-691.

Websdale, N. (1999). *Understanding domestic homicide*. Boston: Northeastern University Press.

Wilson, M.I., & Daly, M. (1993). Spousal homicide risk and estrangement. *Violence and Victims*, *8*, 3-16.

World Health Organization (WHO). 2014. Global status report on violence prevention 2014. . Retrieved January 9, 2016, from http://www.who.int/violence_injury_prevention/violence/status_report/2014/en/

World Health Organization (WHO). 2002. World report on violence and health: Summary. Retrieved January 9, 2016, from http://www.who.int/violence_injury_prevention/violence/world_report/en/summary_en.pdf

World Health Organization (WHO). 2002. World report on violence and health. Retrieved January 9, 2016, from http://apps.who.int/iris/bitstream/10665/42495/1/9241545615_eng.pdf