2010 GEORGIA DOMESTIC VIOLENCE FATALITY REVIEW

ANNUAL REPORT

Georgia Commission on Family Violence
Georgia Coalition Against Domestic Violence

organizing principle: the gaps

ORGANIZING PRINCIPLE: THE GAPS

This year's report addresses the primary reason each state conducts annual reviews of domestic violence (DV) fatalities: the gap between the system's intention to reduce DV-related deaths and the reality that between four and five women are killed daily in this country by present or past intimate partners.[1] This divide represents the difference between what we want and what we have; it is a complex, stubborn breach. Each year we work to better describe and define this distance between victims and the services designated to protect them. **Seven years into this process, we see that the gap is unwittingly sustained by mechanisms of the very systems charged with keeping women safe and holding abusers accountable**. Following are a few obvious, gap-creating mechanisms we experience:

- Georgia's DV victim services programs turned away 2,636[2] victims (including children) who requested shelter in 2010, because of a lack of accommodations.
- Only 19% of victims in fatalities reviewed since 2004 were connected with DV emergency shelter programs.
- Law enforcement bears much of the burden of intervention in DV cases, yet their incident-based response is sometimes a poor fit for the pattern-based abuse that defines much DV. An estimated 55% to 85% of 911 calls relayed to Georgia law enforcement are DV related.[3] In 2009, domestic incidents accounted for 24% of the 49 firearm-related line-of-duty deaths for U.S. officers.[4] Still, specialized training in DV is a rarity in many jurisdictions in Georgia. Escalated hazards plus the lack of specialized training and support compromise first responders' capacity to make victim safety a first priority.
- Calling law enforcement may result in criminal charges, lost family income, escalated violence, and possibly no relief of the victim's suffering.
- While prosecutors understandably prefer clear-cut cases in which the survivor definitively leaves the relationship and agrees to testify fully against the abuser, many DV cases are intrinsically legally problematic. Some DV victims' sense of self may be damaged from years of abuse, their self-efficacy compromised, their internal and external resources and support networks exhausted, their loyalties confused, and they may not want their relationship to end. Other victims may not be confused at all: they may have come to a clear-eyed and entirely rational understanding that their abuser will kill them if they take steps to leave, separate, or testify against him. Indeed, our research has shown consistently that **women in Georgia are most likely to be killed when taking steps to separate from their abusive partner.** Survivors in these circumstances may frustrate the system by appearing confused, belligerent, cowed, or uncooperative with prosecutors and others genuinely concerned with protecting victims. Our legal response best serves a certain, resourceful, and ideal victim, anxious to terminate her relationship with the abuser. This sort of victim rarely exists.
- Most DV victims work outside of the home, and a considerable amount of DV occurs in and around the workplace, but few employers have DV policies, are trained to spot signs and symptoms, or can safely refer victims to help.
- Teens receive little if any information on safe dating or DV resources at school; even if they are alert to DV or stalking, they cannot apply for protective orders without assistance from an adult.

HOW WE ADAPT

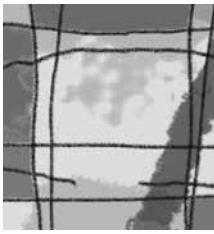
The Project addresses gaps in our ability to keep women safe and gaps in the abuser's control of the victim. **Our primary strategy is to anticipate our systemic lapses so that we can help survivors navigate these gaps as they move towards safety.** If we anticipate the gaps, and help the survivor navigate them, we also undermine the abuser's ability to exploit the gaps to further control and hurt the victim.

One sort of gap holds positive promise: gaps in the abuser's control of the victim. Certain interventions create lapses, providing space for the survivor to move, regroup, connect with other people and resources, and break the isolation that is so damaging. These interruptions in the abuser's control of the victim also provide opportunities for accountability and change for the abuser. Someone intervenes, someone provides space. This intervention may not look like we imagine. There is great potential for intervention while a victim is at work and while she is in her faith community. It may be a friend saying, "Are you ok? This isn't normal." It may be a rabbi giving a sermon about DV, posting resources in the congregation's newsletter and placing brochures in synagogue restrooms. Or, it may indeed be a flashing police light.

One of the most disruptive and volatile breaks in an abuser's control occurs when 911 is called. Officers responded at least 200 times in the 77 fatality cases we have reviewed; clearly all potentially dangerous incidents. We promote specialized roll call trainings for law enforcement to improve safety measures and increase resources offered to the victims during these unique and perilous opportunities. If friends, family, coworkers, and teachers understand and are aware of the signs and symptoms of DV, dating violence, and workplace violence, we can expect these natural helpers to notice, step in, and offer safe help. We can better protect victims as we discover and take advantage of lapses in the perpetrator's direct control of her. These are opportunities to offer victims a safe way to get support, help, and resources. Every time a trusted person lets a victim know she has their support, a potential break in the abuser's control is created.

"**Every victim has a 'safety zone'**; a supplemental relationship, a place they can go (hair dresser, work, school e.g.), a diary, a time in the day, etc., where they can step outside the penumbra of the abuser's control and consider their options and so on. Men go on "search and destroy" missions to identify these gaps and close them, so that the victim has little or no space to breath the air of a free person."

-Dr. Evan Stark



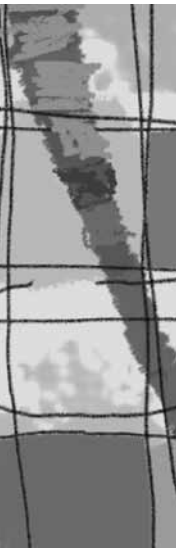
IT IS WHAT IT IS

During the 2010 National Domestic Violence Fatality Review Initiative conference, forensic social worker Dr. Evan Stark spoke eloquently about the gap that separates women's actual experience of DV from our dominant cultural and functional concepts of DV. In *Coercive Control*,[5] Stark contrasts the life experiences of battered women with our present response. He explains that survivors/victims often experience a campaign of low-level violence and control that may not even register with the legal system, since it is designed to respond to severe injury. Much of DV (low levels of violence, emotional abuse, and personal coercion and control) is not illegal, but the abuser's intention is clear: "I control your liberty and life, and I will take your life (or children) if you resist, separate, or leave." Intention is not illegal; the criminal justice system cannot intervene.

Another problematic gap that supports our finding that only 18% of fatality victims reviewed

organizing principle: the gaps (continued)

used available services is identified by Neil Websdale, director of the National Domestic Violence Fatality Review Initiative. Websdale states, "These multiple services that we frequently see as logically laid out to support and protect victims often appear to them to be a confusing, alienating maze."



"The mark of abuse tends to be the frequency and duration of assault rather than its severity. This may be one reason why there were so many police visits in the 77 homicides. The officers take the event seriously, but don't put it into the context of all that has come before. The victim's level of fear is the cumulative byproduct of all that has come before. But when the police compare her level of expressed fear to the incident to which they respond, they can easily conclude she is 'exaggerating' and so they discount her fear. They interpret repeat calls as a woman's not breaking off the abusive relationship. Rather, this is an indication that the abuse is ongoing and that the **police have done something right** or she wouldn't call them again."

-Dr. Evan Stark

Our present reality is that we are working with a complex set of hardworking, non-dovetailing systems and services, each of which has independent accountabilities and objectives to meet while pursuing maximum safety for victims and accountability for perpetrators. Hazardous gaps in service and protection are intrinsic to our system; we can limit their damage by anticipating and including them in our response.

For seven years we have documented how particular women, with every intention of saving their own lives, have attempted to call or called upon the system to help. Various agents, officers, advocates, social workers, family members, employers, and faith-based individuals could not prevent the 107 deaths we have researched since 2004. Only 18% of these fatality victims were in contact with DV emergency shelter programs during the 5 years leading to their deaths. To our knowledge, only 17% were connected to DV-program advocates, our primary experts specifically trained to deal with the victim's challenging and dynamic safety needs. A primary objective of this report is to expand the visibility of and access to community-based DV advocates; dedicated, free and available twenty-four hours a day, seven days a week to engage in survivor-centered advocacy.

REVIEW THE WORK

Since 2004 we have partnered with 20 different fatality review teams across the state to document 82 DV-related fatalities and near-fatality cases. We trained and supported these teams as they wrestled with the gritty reality of how to improve, how to keep women safer, and how to reach out to victims and survivors. Each year we look at who dies in which counties, the victim's source of support, the manner of death, who else was present, who was aware of the abuse, the disposition of calls to 911, prosecution outcomes, and what agencies were involved. We look at known risk factors: previous DV history, unemployment, poverty, and substance abuse. We examine precipitants: looming accountability for the perpetrator, increasing independence of the victim, lack of observers or guardians, financial desperation, and psychological breakdowns.

This work consists of measuring missed connections, tracing what could have been, pursuing what is lacking. After several years of reviews, trends emerged and we could clearly define solid recommendations to better keep victims safer. We necessarily shifted our primary focus away from reviewing cases and toward refining and transmitting what we had learned, passing on both our successes and cautionary

tales. In the last three years, we have been devoted to conducting implementation and supporting teams as they implement our recommendations at the local level.

NEXT STEPS

All evidence suggests that the roots of this gap between our intention to keep women safe and the reality of DV fatalities lie in the domain of disadvantage, fed by social pressures and gender-based inequalities experienced by women in our culture. This is a slippery and confounding cause; problematic to fight. Our tack is to confront the face of this problem and to compensate for its breaches in service with intentional and effective partnerships. If we actively countermand these lapses with connections, bridges, attachments, and collaborations, we eliminate opportunities for abusers to hurt victims.

To that end, in this 2010 Report, we promote:

- Broadcasting community-based **advocates**' expertise and reframing DV programs: inviting all DV responders to include these valuable experts
- **Dating violence** prevention initiatives: connecting stakeholders to resources
- **Workplace** initiatives: linking employers with policies, training, and DV programs
- **Faith**-based initiatives: integrating faith with safety and sanctuary
- **Law enforcement** roll call trainings: partnering DV programs with first responders
- Expanding Georgia's **local fatality review teams**: bridging local gaps

ENDNOTES

1. Catalano, S., Smith, E., Snyder, H., Rand, M. 2009. *Female Victims of Violence*. U.S. Department of Justice, Bureau of Justice Statistics. Retrieved January 1, 2011, from: http://bjs.ojp.usdoj.gov/content/pub/pdf/fvv.pdf.
2. Georgia Department of Human Services. Statistics from state-certified domestic violence programs. Retrieved on January 19, 2011.
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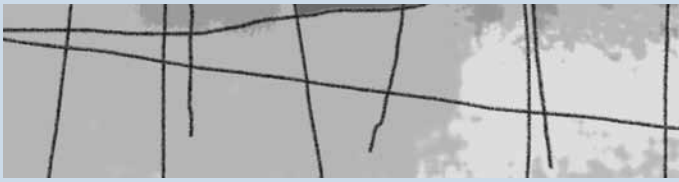
4. National Law Enforcement Officers Memorial Fund. *Law Enforcement Officer Deaths: Preliminary 2010 Research Bulletin*. Retrieved January 1, 2011, from http://www.nleomf.org/assets/pdfs/reports/2010_Law_Enforcement_Fatalities_Report.pdf.
5. Stark, Evan. 2007. *Coercive Control: The Entrapment of Women in Personal Life*. New York, New York. Oxford University Press.



next: advocates

"I HAVE SUCH RESPECT AND ADMIRATION FOR THE ADVOCATES THAT WORK IN MY CIRCUIT. THEY ARE SO DEDICATED AND WORK SO TIRELESSLY ON BEHALF OF VICTIMS AND THEIR FAMILIES THAT THEY MOTIVATE ME TO CONTINUE TO STRIVE FOR SOLUTIONS TO THIS VERY COMPLICATED ISSUE OF FAMILY VIOLENCE. AS I TRY TO BALANCE HOLDING THE PERPETRATOR ACCOUNTABLE AND KEEPING THE VICTIM AND CHILDREN SAFE, ADVOCATES REMIND ME THAT OFTEN VICTIMS ARE FURTHER VICTIMIZED BY THE VERY COURT SYSTEM THAT IS SUPPOSED TO HELP THEM! I APPRECIATE ADVOCATES KEEPING ME MINDFUL THAT EACH CASE IS UNIQUE AND EACH VICTIM HAS A VOICE THAT THE COURT MAY NEED TO HEAR PRIOR TO DISPOSITION OF THE CASE."

-JUDGE NANCY BILLS
ROCKDALE COUNTY STATE COURT
CHAIR, ROCKDALE COUNTY TASK FORCE
AGAINST FAMILY VIOLENCE

Statistics compiled by GCADV and GCFV from its media monitoring services and from reporting domestic violence programs statewide. This count represents all the DV-related deaths known to us at the time of this report. Statistics include intimate partner victims and related persons such as new partners, children and other family members. Statistics also include alleged perpetrator deaths. Most alleged perpetrators who died committed suicide after killing or attempting to kill the victim(s). Deaths of alleged perpetrators are included to show the full scope of loss of life due to DV.

How Many Died from Domestic Violence in Each Georgia County by Year?

Chart 1: Domestic Violence Deaths in Georgia by County 2003-2009

County of Fatality	total annual deaths						
	'09	'08	'07	'06	'05	'04	'03
Appling				4			
Baldwin	2		1	3	3		
Barrow					1	1	1
Bartow			1		2		4
Ben Hill			2			2	1
Berrien			1				
Bibb	7		6	2	6	4	1
Bleckley		1			2		
Brantley		1				1	
Bulloch	2			1			
Burke		3				1	2
Butts			2				1
Calhoun			1				3
Camden					1	1	1
Carroll	3		1	2		1	1
Catoosa	1		1				
Chatham	4	4	2	3	8	2	6
Chatooga	1						
Cherokee	4	4	3		4	1	1
Clarke	10	2	1	2	2		3
Clay	2						
Clayton	1	5	7	11	10	3	3
Cobb	7	4	5	11	8	3	6
Coffee			1		1		
Colquitt			1		3		3
Columbia		1			2		1
Cook			1	2			
Coweta	1	3	2			1	
Crisp			1		1		2
Dawson					1		
Decatur	3	1					
DeKalb	9	13	7	8	3	5	17
Dodge	1			1			
Dooly						1	
Dougherty	1	1	2	1		2	1
Douglas		2				1	1

County of Fatality	total annual deaths						
	'09	'08	'07	'06	'05	'04	'03
Effingham				1			
Elbert	1				1		1
Fannin		1	2		1		1
Fayette			3	1		4	
Floyd	2	2	1	1	1	2	1
Forsyth		3		2			4
Franklin	1					1	
Fulton	11	3	10	4	7	15	10
Gilmer					1		
Glascock					1		
Glynn		1	2	1			2
Gordon	2		1	1		4	
Grady			1				1
Gwinnett	12	6	7	12	12	12	6
Habersham							1
Hall			3	2		2	
Hancock						1	
Haralson							4
Harris	2				2	1	
Henry		1		4	3	1	3
Houston		7		1	2		1
Jackson	2	1		6	1	2	
Jeff Davis		1					
Jefferson				2			2
Jenkins			1	1			
Lamar		1			2		
Laurens		2		1	1	2	2
Lee		1	2				
Liberty				6			4
Lowndes	5				9	1	
Lumpkin						1	
Macon		1			1		
Madison							2
McDuffie		2				2	1
Meriwether		1					
Monroe	2			1			
Montgomery							1

County of Fatality	total annual deaths						
	'09	'08	'07	'06	'05	'04	'03
Murrary	1						
Muscogee	1	8	5	1	9		3
Newton		2	4	3		1	3
Oconee						1	
Oglethorpe	1						1
Paulding	2					2	1
Peach		2					
Pickens			1		1		
Pierce		1					
Pike	3						
Polk			2			2	1
Pulaski	1						
Richmond	4	4	4	1	2	6	4
Rockdale	2		1		3	4	
Schley			1				
Screven				1			
Seminole				1			
Spalding		1	3				
Tattnall	2					2	1
Telfair	2	2		1	3		
Thomas			2			1	
Tift		1	5		1		
Towns						2	
Troup	2	1	1				1
Twiggs						1	
Union	2	2					
Upson						1	2
Walker			1		2		
Walton	1	1				2	
Ware			1		1		
Warren			1				
Washington		2			1		1
Wayne		2	3				4
Webster							1
Wheeler		1					1
White		2				1	2
Whitfield					1	3	2
Worth		2	1				
Undisclosed							3
YEAR	**'09**	**'08**	**'07**	**'06**	**'05**	**'04**	**'03**
TOTAL DEATHS	**123**	**113**	**118**	**106**	**127**	**110**	**137**

Means of Death 2009	firearm	stabbing	blunt force	asphyxiation	burn	unknown	TOTAL
number of deaths	94	12	9	5	1	2	123
percentage of deaths	76%	10%	7%	4%	1%	2%	100%

Chart 1 only includes counties in which a domestic violence homicide was known to have occurred between 2003 and 2009.

charts 2, 3

What Was the Gender of the Victims and Perpetrators, How Were Both Employed, What Were Their Sources of Support?

Chart 2: Gender, Employment, and Income 2004-2010

CHARACTERISTIC	Victim		Perpetrator	
	Number	%	Number	%
Gender				
Female*	74	96%	3	4%
Male	3	4%	74	96%
Employment Status				
Employed	57	74%	46	60%
Employed full-time	40	52%	32	42%
Employed part-time	5	6%	4	5%
Employed, unsure if full-time or part-time	7	9%	6	8%
Self-employed	3	4%	4	5%
Employed part-time and student	2	3%	0	0%
Unemployed	7	9%	12	16%
Retired	2	3%	1	1%
Disabled	2	3%	2	3%
Unemployed student	1	1%	2	3%
Unknown	8	10%	14	18%
Sources of Financial Support				
Personal wages	53	69%	44	57%
No personal income, reliant on perpetrator for financial support	3	4%	0	0%
SSI / SSDI	2	3%	1	1%
Personal wages and family support	3	4%	1	1%
Family support	1	1%	1	1%
Family support, WIC, and Food Stamps	1	1%	1	1%
No income, unknown source of support	1	1%	2	3%
Personal wages & Food Stamps	2	3%	1	1%
Personal wages and alimony	1	1%	0	0%
Widow's pay	1	1%	0	0%
Drug dealing or other illegal income	0	0%	4	5%
No personal income, reliant on victim for financial support	0	0%	7	9%
Retirement pension	0	0%	1	1%
Unknown	9	12%	14	18%

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

Chart 2 Key Points & GAPS

- In line with national statistics, the overwhelming number of homicide victims in reviewed cases were women; the overwhelming number of perpetrators were men.
- GAPS: 74% of victims were employed outside of the home; 52% were full-time employees at the time of their death. Employers and co-workers have the potential to increase victim safety through training on recognizing symptoms, supporting victims, and making referrals.

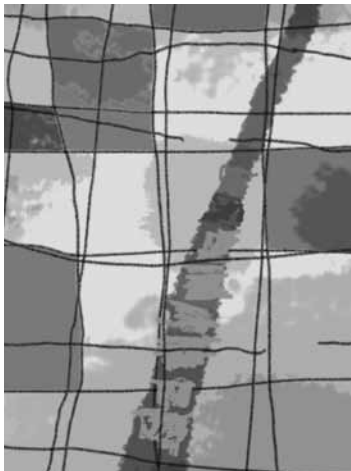
Was it a Single Homicide or Were Others Killed/Hurt?

Chart 3: Types of Incidents 2004-2010

TYPES OF INCIDENTS	Aggregate % for 2004-2010
Single Victim	53%
Homicide + Suicide	22%
Homicide + Attempted Suicide	6%
Homicide + Suicide + Attempted Homicide of Others	4%
Multiple Homicide + Suicide	4%
Multiple Homicide	4%
Homicide + Attempted Homicide of Others	3%
Homicide + Suicide + Others Wounded	1%
Multiple Homicide + Attempted Homicide of Others + Others Wounded	1%
Victim Suicide	1%
Totals	
Incidents Involving Perpetrator Suicide or Attempted Suicide	39%
Incidents Involving Homicide of Others, Attempted Homicide of Others, or Others Wounded	16%

Chart 3 Key Points & GAPS

- In 39% of the cases reviewed, the perpetrator attempted or completed suicide in addition to killing or attempting to kill one or more persons. This finding indicates a significant correlation between domestic violence perpetrators' suicidal thoughts or threats and their danger to others.
- In 16% of the cases reviewed, the perpetrator killed, attempted to kill, or injured someone other than the primary victim. Perpetrators do not limit their violence to their intimate partner. Often, other people close to the primary victim are targeted either because they are with the primary victim at the time of the attack or because the perpetrator intends to cause additional anguish to the primary victim by harming her friends or loved ones.
- GAPS: A perpetrator's threat of suicide is one of the strongest indicators for imminent lethal violence. The Project promotes training of first responders, advocates, attorneys, parole officers, court personnel, social services, and health care personnel to increase vigilance and recognition of this extreme risk factor.



How Were the Victims Killed?

Chart 4: Cause of Death 2004-2010

CAUSE OF DEATH	Aggregate % for 2004-2010
Gunshot	55%
Stab wounds / Stab wounds and lacerations	26%
Strangulation	10%
Blunt or sharp force trauma	6%
Asphyxiation due to smoke inhalation	1%
Multiple traumatic injuries	1%

Chart 4 Key Point

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

For specific information and guidance on teen dating violence and safety issues, see the Ohio Domestic Violence Network's 2010 Teen Relationship Violence Resource Guide. Available from **www.odvn.org**

Who Else Was There When It Happened?

Chart 5: Who Else Was Present, a Witness to, or Killed at the Fatality 2004-2010

PRESENT, WITNESSED, OR KILLED	Present		Witnessed		Killed	
	Actual number of people	% of total 2004-2010 cases	Actual number of people	% of total 2004-2010 cases	Actual number of people	% of total 2004-2010 cases
TOTAL	**186**	**57%**	**156**	**47%**	**7**	**9%**
Children	66	43%	50	19%	3	4%
Family members	21	18%	13	6%	3	1%
Friends	5	5%	4	4%	0	0%
New intimate partners	3	4%	2	3%	1	1%
Co-workers	3	3%	3	1%	0	0%
Acquaintances or neighbors	17	9%	14	9%	0	0%
Strangers	71	8%	70	8%	0	0%

Chart 5 Key Points & GAPS

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

- 2004-2010 data indicate that in 57% of cases someone was present at the scene of the fatality. 47% of the time someone witnessed the homicide. In 9% of cases, someone other than the primary victim was killed.
- In 19% of cases, children witnessed the homicide.

- GAPS: Contrary to popular understandings of domestic violence as a "private" issue, it is often the case that people other than the victim and the perpetrator are present at, witness to, or killed during a domestic violence homicide. The violence often spills over to affect family, friends, and bystanders.
- GAPS: There is a critical need to assist children in dealing with the traumatic effects of witnessing the homicide of a loved one and losing one or both parents.

chart 6

Who Was Aware of the Perpetrators' Behaviors?

Chart 6: Perpetrators' History as Known by the Community 2004-2010

PERPETRATORS' BEHAVIORS		Percentage of cases where this factor was present	WHO WAS AWARE?				
			Family and friends	Law enforcement	Criminal courts	Civil courts	Service providers
Violent or criminal behavior	History of DV against victim	90%	74%	62%	23%	22%	29%
	Threats to kill primary victim	60%	63%	41%	17%	26%	17%
	Violent criminal history	53%	44%	88%	39%	10%	24%
	Stalking	44%	62%	32%	9%	6%	12%
	Threats to harm victim with weapon	39%	57%	37%	17%	7%	17%
	Child abuse perpetrator*	33%	47%	47%	24%	35%	41%
	History of DV against others*	29%	53%	67%	40%	13%	7%
	Inflicted serious injury on victim*	27%	100%	57%	50%	0%	43%
	Sexual abuse perpetrator	23%	50%	39%	6%	22%	11%
	Strangulation	21%	44%	50%	31%	6%	19%
	Threats to kill children, family, and/or friends*	21%	73%	64%	36%	18%	9%
	Harmed victim with weapon*	13%	71%	71%	57%	0%	43%
	Hostage taking*	8%	75%	50%	50%	25%	50%
Controlling behavior	Monitoring and controlling	57%	77%	14%	0%	9%	14%
	Isolation of victim*	35%	89%	0%	0%	6%	6%
	Ownership of victim*	25%	100%	8%	0%	8%	15%
Mental health issues and substance abuse	Alcohol and drug abuse	55%	67%	57%	24%	12%	26%
	Suicide threats and attempts	39%	57%	30%	7%	7%	33%
	Depression*	29%	73%	27%	13%	20%	67%

*Includes cases reviewed in 2005-2010 data only.

Chart 6 Key Points and GAPS

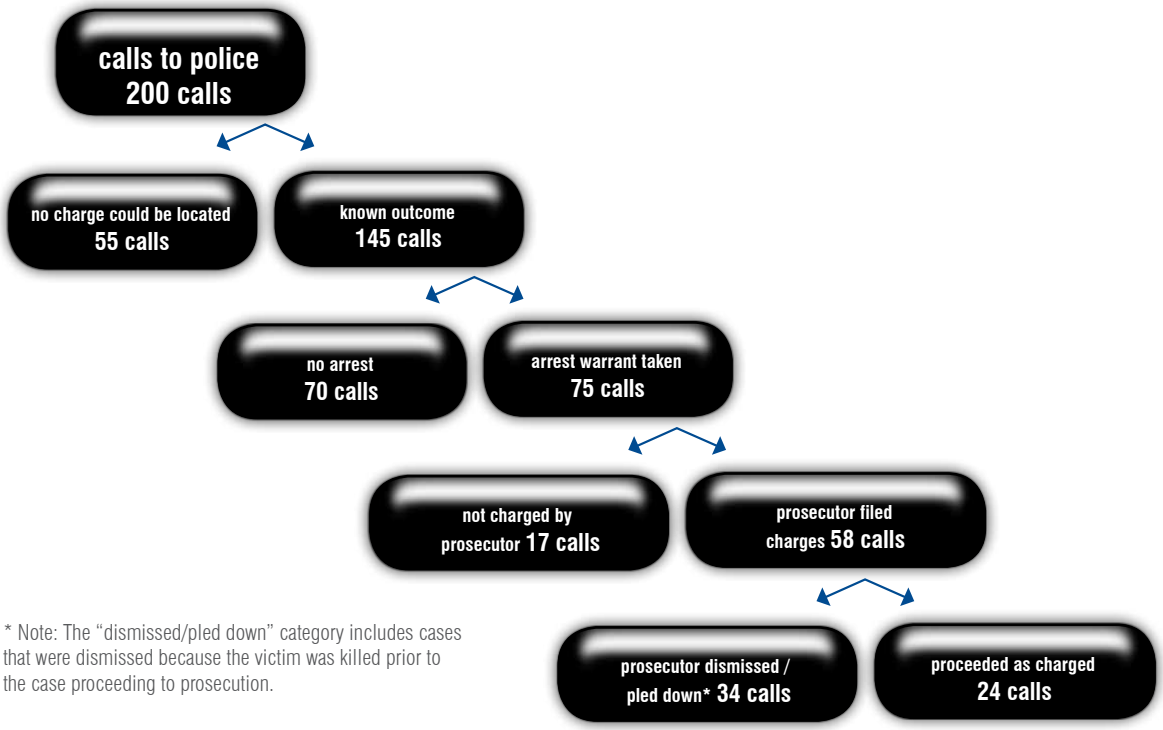
Information for this chart was gathered primarily through available protective order petitions, police reports, prosecutor files, homicide investigations, and interviews with family and friends. Project Coordinators then categorized these behaviors based on commonly used guidelines for lethality indicators.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

Here is an example of how this chart may be read: **"In cases where monitoring and controlling behaviors were present, family and friends knew about this in 77% of those cases."**

- In cases where the perpetrator had inflicted serious injury on the victim, family and friends were aware of this fact 100% of the time, yet law enforcement was only aware of this fact 57% of the time. This reminds us that law enforcement often has limited information about the relationship and reinforces the critical role of those very knowledgeable parties: victims' friends and family.
- In 90% of the cases, the perpetrator had a history of some DV against the victim prior to the homicide. A good indicator of future and possibly lethal violence is past violence.
- In only 27% of the cases did the perpetrator inflict serious injury on the victim in an incident prior to the homicide. This suggests that while serious or visible injury is a predictor of future and possibly lethal violence, it will not always be present in cases where victims are later killed.
- GAPS: These numbers reveal that family and friends of the victim generally have the most information about the relationship, yet they often do not know how to help.
- GAPS: Perpetrator's DV history may be invisible to first responders; the most vital lethality indicator can easily be missed.
- GAPS: In the majority of cases, family and frends were very aware of the perpetrator's controlling behaviors, but the rest of the system was only marginally aware.

What Was the End Result of Calls to 911?

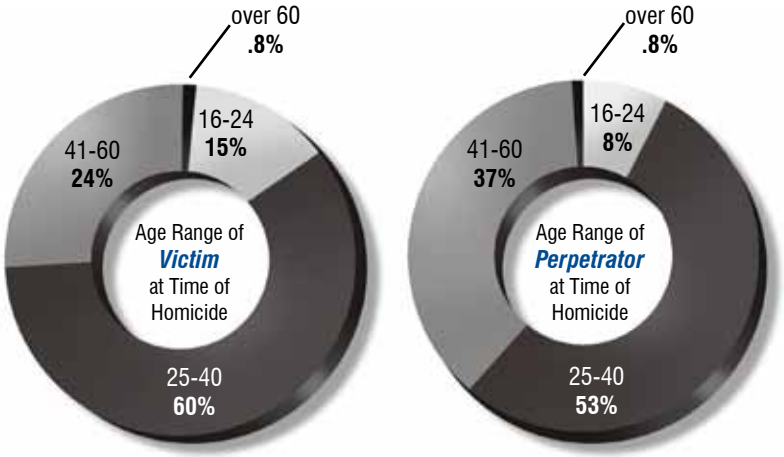
Chart 7: Detail of Investigation and Prosecution Outcomes 2004-2010



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

What Proportion of Victims and Perpetrators Were in Each Age Range?

Chart 8: Victim and Perpetrator Ages at Time of Homicide 2004-2010



Convenience sample of 75 homicide victims, 75 perpetrators. The average age of victims at death was 35 years; perpetrator's average age was 36.5 years at the time of the homicide.

Chart 8 Key Points & GAPS

- In our reviews, over one half (52%) of our victims were between the ages of 16-24 when they began their relationship with the partner who eventually killed them.
- Over one quarter (29%) were teenagers when they began relationships with the partners who killed them; five of the victims were just 15 when their relationships began.
- GAPS: Our lack of recognition of, resources for, and effective responses to teen dating and young relationship abuse represent critical missed opportunities for preventive interventions.

Chart 7 Key Points & GAPS

- When law enforcement was called to the scene, 63% of the time no arrest warrant was taken or no evidence of a charge could be located. This percentage includes cases where the law enforcement officer did not take a warrant because the perpetrator had left the scene. It also includes cases where the perpetrator remained on the scene and the officer advised the victim to take the warrant herself. **These practices send a message to the victim that the crime committed against her is not being taken seriously by the criminal justice system. Additionally, they send the message to perpetrators that the criminal justice system will not hold them accountable for their behavior.**
- GAPS: A review of the case histories reveals that calling law enforcement does not always result in increased safety, justice, or perpetrator accountability. In those cases where law enforcement was called and the outcome is known, only 29% were charged by the prosecutor, and 59% of those were subsequently either dismissed or pled down.

chart 9

Which Agencies and Services Interacted with Victims and/or Perpetrators?

Chart 9: Agencies and Services Involved with Victims or Perpetrators in the Five Years Prior to the Fatalites 2004-2010

AGENCY / SERVICE / PROGRAM		VICTIMS		PERPETRATORS	
		Number	% total cases	Number	% total cases
Justice System Agencies	Law enforcement	60	78%	65	84%
	County prosecutor	30	39%	37	48%
	Superior court	25	32%	30	39%
	Magistrate court	23	30%	30	39%
	State court	18	23%	16	21%
	Civil court, including juvenile court	18	23%	17	22%
	Protection order advocacy program	13	17%	1	1%
	Court-based legal advocacy	13	17%	2	3%
	Probation	7	9%	27	35%
	Municipal court	5	6%	9	12%
	Legal aid	4	5%	0	0%
	Parole	1	1%	8	10%
	City prosecutor	1	1%	5	6%
Social Service Agencies	Child protective services (DFCS)	9	12%	9	12%
	Child care services	4	5%	2	3%
	TANF or Food Stamps	4	5%	2	3%
	WIC	3	4%	0	0%
	Homeless shelter	2	3%	1	1%
Health Care Agencies	Hospital care	16	21%	14	18%
	Private physician	15	19%	13	17%
	Emergency medical service (EMS)	13	17%	6	8%
	Emergency medical care	13	17%	6	8%
	Mental health provider	8	10%	18	23%
	Medicaid	3	4%	0	0%
	Substance abuse program	2	3%	4	5%
	PeachCare	1	1%	0	0%
Family Violence Agencies	Domestic violence shelter/safe house	14	18%	0	0%
	Community-based advocacy*	13	17%	4	5%
	Family violence intervention program (FVIP)	1	1%	10	13%
	Sexual assault program	1	1%	0	0%
Miscellaneous Agencies	Religious community, church, temple, or mosque	23	30%	14	18%
	Immigrant resettlement	2	3%	1	1%
	English as a Second Language (ESL) program	1	1%	0	0%
	Anger management	0	0%	5	6%

*Community-based advocacy is defined as non-residential domestic violence services

Chart 9 Key Points & GAPS

- Law enforcement had the most contact with both victims and perpetrators prior to the homicide. Continued law enforcement training on the dynamics of domestic violence (DV) and how/where to refer DV victims for services is needed. **See section on "roll call" trainings for information on strategies for change.**
- GAPS: **Only 18% of DV homicide victims were in contact with a DV shelter or safehouse** in the five years prior to their death. DV programs need to take proactive steps to ensure that their full range of services are known, accessible, culturally relevant, and inviting to DV violence victims.
- GAPS: A significant number of perpetrators and **victims interacted with a religious community, church, temple, or mosque** in the five years prior to the homicide. Faith communities have great potential for offering resources, referrals, and safety to congregants.

BRINGING IN LOCAL DV PROGRAMS TO DELIVER CRUCIAL INFORMATION ABOUT SERVICES.

Just as victims and perpetrators of domestic violence exist across multiple systems, solutions to DV are to be found within and between multiple systems. Survivors of domestic violence who regularly call law enforcement for emergency intervention use other support systems far less frequently, if at all. In this 2010 Report, Chart 9 (page 30) indicates that while 78% of DV homicide victims had contact with law enforcement, only 18% had ever utilized DV program emergency shelter and just 10% had used counseling services. These non-governmental resources are all confidential and free of charge. **Clearly, law enforcement has a primary role in connecting survivors of domestic violence with the information they need to access vital services.** Learning about local DV program services is critical to survivors, regardless of the outcome of their call to 911. Bringing local DV programs into targeted roll call trainings is an effective and creative strategy to answer victim's needs.

Law enforcement officers are mandated by state statute to notify DV victims of available services and remedies, both governmental as well as non-governmental. DV program directors, legal advocates, and other program staff are best qualified to deliver details of their services for survivors. Law enforcement roll call trainings provide an excellent format for this type of information exchange. **Many officers are unaware of the full scope of services offered by DV programs and that many services are available for victims still in the abusive relationship.** Roll call training provides an opportunity for law enforcement to put a name and face to specific programs and services. The more familiar law enforcement becomes with the people and services of the DV program, the more likely they are to pass that information along to victims. In communities where law enforcement works collaboratively with other service providers, there is a marked decrease in DV crime and homicides.

Georgia has unique challenges with regard to training of law enforcement officers. The state has 159 counties divided into 49 judicial circuits. There are over 1,000 law enforcement agencies employing close to 55,000 certified law enforcement officers. Fifty-eight percent of the law enforcement agencies in Georgia operate with eight or fewer officers or deputies. A survey of police chiefs and sheriffs in Georgia revealed that, depending on the demographics of the area served, 55%-85% of calls to law enforcement were domestic related or for domestic violence.[1] **Roll call training sessions provide an opportunity to present a consistent message across the state to law enforcement officers and agencies.** Roll call training sessions are also beneficial to local DV programs' advocates and staff, who can become more familiar with line officers, supervisors, and administrators of local law enforcement agencies. This training strategy broadcasts crucial information effectively while promoting multiple system collaborations and encouraging partnerships.

ENDNOTES

1. 2005 survey of police chiefs and officers in the state of Georgia inquiring about relative percentage of 911 calls relating to domestic disturbance. Conducted by Grant Programs Administrator, Georgia Association of Chiefs of Police.

EASY STEPS TO SET UP A ROLL CALL TRAINING

For Law Enforcement interested in receiving roll call training: call GCFV at 404-657-3412

For DV Programs who would like to present roll call trainings call GCADV at 404-209-0280

ROLL CALL TRAINING FAQS

Q What is the purpose?

A Twofold: To help law enforcement officers understand what services are available to DV victims so that they can relay this to victims they serve. Also to foster trusting relationships between law enforcement and DV program advocates

Q How long does each training last?

A 10 minutes

Q Who presents?

A The victim advocate from a local DV program

Q What topics are covered?

A Officers learn about:

- ✯ Services available to residents
- ✯ Emergency services
- ✯ Crisis line services
- ✯ Children's services
- ✯ Services available to non-residents
- ✯ Legal advocacy for victims
- ✯ Length of resident's stay at shelter
- ✯ Confidentiality issues
- ✯ Costs of services to victims

Q What is the fee for roll call trainings?

A There is no charge

roll call trainings: gwinnett implements change

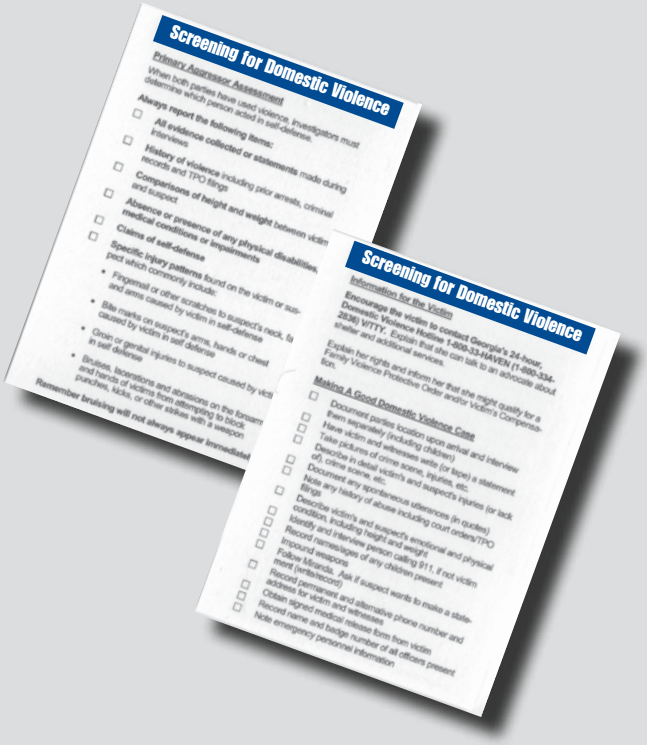
HOW GWINNETT COUNTY FAMILY VIOLENCE TASK FORCE IMPLEMENTED ROLL CALL TRAININGS

Our Community Response subcommittee of the Gwinnett County Family Violence Task Force was moved when reading Georgia's 2009 Fatality Review findings about victims' contact with law enforcement. **Seeing that 78% of victims had contact with law enforcement, yet only 18% were in contact with DV emergency shelter programs drove us into action to address this gap. We believed that we could take steps to ensure that victims received more information about critical, free services meant to protect and even save them.** The choice to use roll call trainings came about because one committee member, Jeanette Soto from PADV, recalled a similar training that PADV had provided for the police in another county. We implemented this idea with our own Gwinnett County resources. Our task force has two law enforcement members, Phil Raines and Natasha Burney, who provided introductions to police precinct chiefs. Phil and Natasha arranged for our trainings with each precinct chief, and we were granted 10 minutes with each shift immediately after roll call. We presented to each precinct over two to three days, at 6:30 a.m., 2:30 p.m., and 10:30 p.m. In this way, we were sure to address all of the line officers.

During these 10 minutes, we presented an overview of domestic violence, explained the task force's activities and distributed updated victim resource lists for Gwinnett County. The officers were able to ask questions; this resulted in some great feedback from them. At each roll call training we had one task force member plus either Phil or Natasha. We presented first to the big precincts – North, South, East, West, and Central – and now we are beginning on the city precincts.

This task requires a lot of dedication and many volunteers, but it has been truly beneficial. Now we are developing pocket cards with information from the solicitor's office for the police officers to give to victims during 911 domestic disturbance interventions. **With Phil's help, we were also able to get our updated resource list loaded into the squad car laptops.** Now the officers can easily look up specific resources for individual victims as needed. We are planning to increase our volunteer staff and streamline our plan as Gwinnett's city precincts are more numerous. Our next step is to interview prosecutors at the district attorney's office to determine what they feel they need to prosecute a case; then we will present this information at future roll call trainings.

With the help of the Georgia Commission on Family Violence and the Georgia Coalition on Domestic Violence, we were able to host a training for other Georgia fatality review board members on how to implement roll call trainings. **It is really gratifying to know that steps we are taking to get good information out to officers is helping them to better serve victims.** We hope to continue our efforts into the next year.



Above are **Law Enforcement "Screening for Domestic Violence" Pocket cards,** available at no cost from GCADV at 404-209-0280.

macon: fatality review team from scratch

Macon's Central Georgia Council on Family Violence (CGCFV) had been in existence for over four years when they decided to create a fatality review team subcommittee. Frank Mack, Executive Director of the Family Counseling Center of Central Georgia, is a member of the CGCFV and led the initiative. Mack notes, **"While we felt we were doing a credible job of educating our community on family violence, we continued to suffer family violence fatalities. We knew we needed to learn more about DV fatalities and explore ways that the Macon community could better protect DV victims."**

Mack and Allison Owen, LMFT on staff at the Family Counseling Center of Central Georgia, first contacted Georgia's Fatality Review Project, who helped them build a team, adopt policies and procedures, and educate the team on the complexities of domestic violence. The Project advised them on selecting only adjudicated cases, developing a case chronology, techniques to appropriately interview the victim's family and friends, how to best interview law enforcement and victim service providers, and how to avoid the "blame game."

Mack's group was very particular about the team they assembled, choosing members already highly invested in the processes of responding to victims or creating and enforcing accountability for offenders. They attracted an assistant pastor experienced in educating the community on DV issues as well as one attorney, one investigator, and one victim's advocate from the district attorney's office. Additionally, there were two attorneys from Georgia Legal Services, a lieutenant from the Macon Sheriff's Department, a representative from the Macon Police Department, a DFCS/RiverEdge Behavioral Center employee, a representative from a DV program/shelter, and a chief probation officer sensitive to DV safety issues. Mack states that several people were especially critical to the team's successful fatality review. **"Key staff from our district attorney's office, Georgia Legal Services, and Family Counseling Center of Central Georgia played critical roles in gathering information on the case we selected, and in appropriately interviewing family and friends of the victim."** The team appreciated the support it received from CGCFV and the guidance and technical assistance that came from Georgia's Fatality Review Project.

Mack notes that everybody came at the issue of DV fatalities from different directions, each carrying the expertise and baggage of their particular profession. He was pleased that members were able to balance their own agendas with the group goals, and that they collectively came to see how they could change and improve the ways they were dealing with DV.

When asked how they came to choose the particular case they reviewed, Mack explained that the district attorney had offered four cases as candidates for review. The group reviewed these and unanimously chose one that "really bothered everyone. It was so egregious, and so unacceptable that this had happened in our town, on our watch." This fatality review team intuitively understood that there is much to be learned from cases that can feel most damning of well-intentioned services and most embarrassing to a caring community.

"My biggest surprise was that many of the individuals connected to this case lacked knowledge of all of the resources that were available and many lacked a clear understanding of the complexities and realities of family violence. As a result, our committee, with support of the CGCFV, is developing new strategies to educate our community on the cycle of family violence and to broadcast information on the many resources that are available in our community," states Mack. Clearly, the gaps between a victim's needs, her ability to access help, and the availability of safety and resources confounded Macon's Fatality Review Team as it does teams and DV professionals throughout Georgia. *(continued on next page)*

macon: fatality review team from scratch (continued)

Macon's process had a unique feature that has become the new model in Georgia for best practices when interviewing family members and friends of fatality victims. For the first time, this team used the same caring protocol to interview the victim's family and friends that had been used in Georgia's near-fatality interviews. Family Counseling Center's therapist Allison Owen was present before, during, and after the interview to help debrief, and other safety precautions were taken as well. The response from those interviewed was so positive that the Georgia's Domestic Violence Fatality Review Project has integrated this protocol into existing interview procedures.

Mack's suggestion for communities considering fatality review is "to first determine if their community is committed to taking an honest look at DV fatalities in their community; decide who will provide the leadership for a fatality review team; seek assistance from the Georgia's Fatality Review Project, and last but not least, understand that this process is not about blaming anyone."

POPULARITY POSED A PROBLEM

Armed with what they had learned in the training, they formed a fatality review sub-committee to their task force, and were quickly overwhelmed with task force volunteers for this committee. Everyone seemingly wanted in and this subcommittee quickly became the largest they had, by far. Understandably, their law enforcement representatives were uncomfortable revealing murder case details to so many people and a case was never identified for review. Barbara Hogan, **Task Force Director, now feels that starting a fatality review subcommittee with a select few representatives first, then recruiting additional members more slowly, would be a more productive approach.**

REALITIES OF RECESSION A BARRIER

When the idea of a fatality review committee was introduced, task force members felt too taxed adding another meeting to their already heavy workloads. They decided to toggle meetings, cutting back task force meetings to every other month, alternating months with subcommittees meetings. The fatality review team began meeting every other month, but they quickly sensed it was not a productive schedule. It was not an option to ask members to meet more often because many of them were employed in departments and organizations that were cutting positions and adding to their workloads. **The Executive Board was clear that the sluggish economy had taken its toll on all agencies**; everyone had to do more with less. Sensibly, the Executive Board decided to suspend the Fatality Review Committee until they could reasonably regroup.

DOING THE WORK OF FATALITY REVIEW WITHOUT REVIEWING A CASE

In the meantime, the Executive Committee made a commitment to not let the idea of fatality review fade away completely. Recalling a key message from their 2009 training, they turned their attention to the findings and recommendations printed in the Georgia Domestic Violence Fatality Review Project's 2009 Annual Report. They focused on three specific issues and devised particular tactics and strategies to respond to each. Following is a summary of their focus, work, and accomplishments:

FAITH AND DOMESTIC VIOLENCE

Victims, survivors, and their family members consistently turn to their faith communities for support and safety, whether they disclose the abuse or not.

spotlight douglas county

At the urging of Judge Peggy Walker, in 2009 the Douglas County Task Force on Family Violence decided to collectively get involved in Georgia's Domestic Violence Fatality Review Project. They invited the Project Coordinator from Georgia Commission on Family Violence (GCFV) to present on what their participation could involve. Their interest was piqued; soon after, they sent representatives to the Fatality Review overview training offered by GCFV and GCADV. They saw that they could not only learn from their own experiences but could also benefit from lessons learned from fatality reviews in other jurisdictions.