

*Through the Eyes of the Victim:  
Project Report and Recommendations  
of the Domestic Violence Fatality  
Review Statewide Steering Committee*



**FCADV**  
Florida Coalition Against Domestic Violence

# Acknowledgements

Thanks to the members of the Statewide Steering Committee for their expertise and guidance.

Thanks to the eighteen local fatality review teams for their participation in this project, and for their dedication and hard work conducting fatality reviews in their communities.

Thanks to Dr. Neil Websdale and Matthew Dale for their contributions to this project and to this Project Report and Recommendations.

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## **I. Introduction**

The Department of Children and Families (DCF) received an award from the Grants to Encourage Arrest Policies and Enforcement of Protection Orders Program, administered by the Department of Justice, to partner with the Florida Coalition Against Domestic Violence (FCADV) to create a statewide domestic violence fatality review steering committee. The two year grant enabled the Steering Committee to meet four times to:

- Identify gaps in service delivery to domestic violence victims and identify potential systemic breakdowns.
- Promote training and cross-training to professionals.
- Coordinate the activities of agencies involved and share and exchange information.

This grant award came at a critical time in Florida, where in 2007, 16 percent of the homicides were domestic violence related (Florida Department of Law Enforcement, Annual Crime Report).<sup>1</sup> Of these offenses, the spouse or live-in partner was the victim in 56 percent of the cases, and children accounted for 12 percent of the victims. Of the 189 domestic violence homicides reported statewide in 2007, 66, or nearly 35 percent, were committed within the jurisdiction of active fatality review teams (FDLE Domestic Violence Fatality Review Team 2008 Annual Report Executive Summary).

The fatality review process is a critical component in helping communities understand the events that may have led to a domestic violence homicide, and ultimately to determine how to prevent such homicides. Florida fatality review teams are governed by Chapter 741, Florida Statutes. Section 741.316(2) provides that:

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<sup>1</sup>It is probable that these numbers were even higher, as statistics typically underestimate the proportion of homicides attributable to domestic violence. See, Websdale, Neil, Understanding Domestic Homicide 1999.

A domestic violence fatality review team may be established at a local, regional, or state level in order to review fatal and near-fatal incidents of domestic violence, related domestic violence matters, and suicides. The review may include a review of events leading up to the domestic violence incident, available community resources, current laws and policies, actions taken by systems and individuals related to the incident and the parties, and any information or action deemed relevant by the team, including a review of public records and records for which public records exemptions are granted. The purpose of the teams is to learn how to prevent domestic violence by intervening early and improving the response of an individual and the system to domestic violence. The structure and activities of a team shall be determined at the local level. The team may determine the number and type of incidents it wishes to review and shall make policy and other recommendations as to how incidents of domestic violence may be prevented.

The statutes governing fatality review teams are included in Appendix 1.

## **II. Project Summary**

### **A. Statewide Fatality Review Steering Committee**

In April 2008, DCF and FCADV created the Statewide Domestic Violence Fatality Review Steering Committee, with representatives of the following state agencies and organizations serving on the committee: Florida Department of Children and Families; Florida Coalition Against Domestic Violence; Florida Department of Law Enforcement; Florida Sheriff's Association; Florida Police Chiefs Association; Florida Prosecuting Attorneys Association; Office of the Attorney General; Office of the State Courts Administrator; Florida Department of Education; Florida Department of Corrections; Clerk of Court and Comptroller's Office; Medical Examiner's Office; Office of the State Attorney; Florida Department of Health; Certified Domestic Violence Centers; Batterer's Intervention Program; and a citizen-at-large who is a survivor of domestic violence. A roster of the committee members is in Appendix 2.

### **B. Project Consultants**

Dr. Neil Websdale and Matthew Dale, national experts on domestic violence fatality review, served as consultants to the project and conducted two statewide domestic violence fatality review trainings. Dr. Websdale is Professor of Criminal Justice at Northern Arizona University and Principal Project Advisor to and former Director of the National Domestic Violence Fatality Review

Initiative (NDVFRI). He has published work on domestic violence, the history of crime, policing, social change, and public policy, including four books: Rural Woman Battering and the Justice System: An Ethnography (Sage Publications), 1998, which won the Academy of Criminal Justice Sciences Outstanding Book Award in 1999; Understanding Domestic Homicide (Northeastern University Press), 1999; Making Trouble: Cultural Constructions of Crime, Deviance, and Control (Aldine Books, co-edited with Jeff Ferrell), 1999; and Policing the Poor: From Slave Plantation to Public Housing (Northeastern University Press), 2001, winner of the Academy of Criminal Justice Sciences Outstanding Book Award in 2002 and the Gustavus-Myers Center for the Study of Bigotry and Human Rights Award in 2002. His next book, Familicidal Hearts, is due out January 2010, published by Oxford University Press.

Mr. Dale is the director of the Montana Department of Justice's Office of Consumer Protection and Victim Services. Mr. Dale's work in the area of family violence includes staffing the Montana Domestic Violence Fatality Review Team, which visits communities that have experienced a recent death as a result of family violence. Team members work with agencies in the affected community, including law enforcement, victim services, tribal governments, clergy, medical providers, child welfare, batterers' treatment and the courts, to identify gaps in services in an attempt to prevent future homicides. Mr. Dale has also served as a senior consultant for NDVFRI and has given numerous presentations across the country on fatality review. He has published in the *Fatality Review Bulletin* and the journal *Violence Against Women*.

### **C. Statewide Steering Committee Meetings**

The Statewide Steering Committee held its initial meeting on May 29, 2008, in Tallahassee, with 14 members in attendance. For three hours, the committee discussed challenges relating to domestic violence fatality review on both the statewide and local levels. Local fatality review team representatives from Miami-Dade, Palm Beach, Polk, Highlands, and Duval Counties and the Third Judicial Circuit (Columbia, Madison, Taylor, Dixie, Lafayette, Hamilton and Suwannee

Counties) attended this meeting, and reported on their structure and the types of cases they review. Reports from the local teams emphasized the differences in their operations, as well as the differences in funding. For example, the Miami-Dade team is funded by the county, and has full-time staff devoted to domestic violence fatality review. Other teams rely on volunteers from various agencies to conduct reviews. Teams also discussed the findings in Florida State University Institute for Family Violence Studies' report, "Florida's Domestic Violence Needs Assessment for 2006-2007". That document identified the following needs in families impacted by domestic violence:

- Cultural Competence. This term is used to reflect services needed by non-English speakers, the disabled, elderly, and other disenfranchised populations.
- Housing. There is a shortage of low income and/or transitional housing available to survivors of domestic violence and their children.
- Mental Health Services. There is a scarcity of available mental health services, particularly in rural areas.

Members of the Steering Committee who provide direct services to victims confirmed that these identified needs are consistent with the challenges faced by domestic violence survivors. The need for bilingual service providers and court interpreters is frequently unmet, making non-English speakers reluctant to access services. While certified domestic violence centers provide shelter to survivors and their families, shelter stays are time-limited, and finding transitional and affordable housing for survivors is increasingly difficult. Direct service providers reported also an increase in the complexity of mental health needs of survivors and their children and a decrease in the availability of services, particularly in rural areas.

The Statewide Steering Committee held its second meeting in Tallahassee on November 18, 2008, with 20 members in attendance. Project consultants Websdale and Dale facilitated the team's discussion at the meeting and identified national and statewide trends in

domestic violence fatalities. Team members identified and discussed possible gaps in law enforcement, civil and criminal court, social services, education, and other systems in Florida that contribute to these trends. DCF representatives reported the results of a study conducted by the DCF Domestic Violence Program Office that determined that 99% of all the women who died as a result of domestic violence from 2005 to mid-2006 never stayed in shelter, and 95% had no contact with a certified domestic violence center within five years of their murder. Committee members also discussed ideas for outreach to address prevention of domestic violence, as well as the role of a statewide domestic violence fatality review team, and how a statewide team could assist local teams.

The Steering Committee held its third meeting on April 6, 2009, in Jacksonville. Fourteen members attended. Dr. Nancy S. Hardt, Professor of Pathology and Obstetrics and Gynecology at the University of Florida College of Medicine, presented her research on maternal death due to trauma in Florida and its relationship to domestic violence fatalities. Her presentation resulted in discussion among team members regarding types of data that may be helpful to fatality reviews, agencies that collect such data but do not currently participate in the fatality review process, and possible future collaborations with data sharing.

The Steering Committee held its final meeting on August 20, 2009, in Fort Lauderdale. Fourteen members attended. The Steering Committee provided additions and edits to a draft of this Project Report and Recommendations. They also discussed alternative funding sources and other potential resources to continue the work of the Steering Committee to assist local fatality review teams. Possible topics for a more advanced statewide training on domestic violence fatality review were also considered.

#### **D. Fatality Review Training Institutes**

Project consultants Websdale and Dale conducted one-day trainings on domestic violence fatality review in Jacksonville (April 6), with over 70 attendees, and Fort Lauderdale (August 21)

with over 80 attendees. Participants included local fatality review team representatives, domestic violence centers, law enforcement, criminal justice personnel, child welfare workers, and health and family service providers. Current national trends in domestic violence fatality review were discussed and attendees participated in mock reviews based on actual domestic violence homicides. Post-tests administered at the trainings demonstrated an increase in knowledge and evaluations of both trainings were overwhelmingly positive.

#### **E. Electronic Newsletters**

During the project period, FCADV drafted and distributed four Domestic Violence Fatality Review ENewsletters to all manner of governmental and nongovernmental agencies. The newsletters are in Appendix 3.

#### **F. FCADV Webpage**

FCADV created and continuously updated a webpage dedicated to domestic violence fatality review. The webpage contains statutes and links to numerous articles and resources related to fatality review both in Florida and nationally. The webpage is available at [www.fcadv.org](http://www.fcadv.org).

#### **G. Local Fatality Review Team Activities**

Following are the results of a survey conducted by the Statewide Steering Committee concerning recent activity and types of cases reviewed by local fatality review teams in Florida during 2008-2009. A roster of current local fatality review teams is in Appendix 4.

**Brevard County's** team reviews homicides and homicide-suicides. The team reviewed three cases in 2008 and one thus far in 2009.

**Broward County's** team reviewed two murder-suicides in 2008. The team reviews homicide-suicides and near-death cases.

**Duval County** reviews homicides and homicide-suicides of intimate partners. The team reviewed 10 cases in 2008.

**Hillsborough County's** team reviews intimate partner homicides. The team reviewed four cases in 2008 and four cases thus far in 2009.

**Miami-Dade County** reviews approximately two cases per month including the following types of cases: familiar DV-related deaths; sexual competitors; so called mercy killings; DV-related suicides; DV-related near-death Victims and Child Abuse/Neglect Deaths.

**Palm Beach County** reviewed four homicide-suicide cases. The team reviews the following types of cases: near fatal/attempted murder; domestic/intimate partner; same sex/significant other; dating relationships; and aggravated battery/attempted murder.

**Pasco County** reviews homicide-suicides, suicide-near-deaths, and cases in which the perpetrator attacked a child or attacked the victim's new partner.

**Pinellas County** conducted six reviews in 2008 and 20 reviews so far in 2009. The team reviews intimate partner fatalities and near-fatalities, homicide/suicides, and familicide/suicides.

**Polk/Highlands Counties** reviewed three cases: an intimate partner homicide, a murder suicide, and a case where an ex-girlfriend and her new boyfriend killed the ex-boyfriend.

**Santa Rosa County** is in the process of separating from the joint Escambia and Santa Rosa Counties' team and plans to review its first case in October 2009. The team will focus on fatalities and near-death or death/suicide cases.

**Seminole County** plans to meet in June and September 2009 with the intent of meeting quarterly. The team plans to review nine domestic violence homicides that occurred in 2008.

**Alachua, Sarasota/Manatee and St. John's Counties** are in the process of forming or reactivating their fatality review teams and determining the types of cases to be reviewed.

### **III. Recommendations of the Statewide Steering Committee**

This grant enabled DCF and FCADV to bring together high ranking officials or their designees from almost every state agency in Florida, along with state and local civil and criminal justice associations and community partners, to discuss domestic violence fatality review. It was unprecedented to have officials at this level at the same table to discuss this topic. The experience and expertise of each member, as well as the guidance provided by the project consultants, enabled the Steering Committee to discuss potential gaps in systems serving victims and perpetrators of domestic violence, and to brainstorm ideas to address those gaps, with an eye toward the ultimate goal of increasing services to families and preventing domestic violence homicides. The interaction between officials of various agencies has also led to the development of new partnerships at the statewide level to address domestic violence, including partnerships between FCADV and the Department of Corrections, and FCADV and the Department of Education.

A guiding principle of the Steering Committee in developing its recommendations was the recognition that it is critical to view system response to domestic violence through the eyes of the victim. It is one thing for a group of providers to meet and analyze gaps in services through the lens of a player in the system. It is quite another to look at the choices a victim may have to make as she navigates through referrals and services offered.

## **Recommendation 1**

Communities should actively encourage and develop collaborations and coordination among all agencies and service providers to increase awareness of available programs. Such agencies include, but are not limited to, domestic violence centers, law enforcement, courts, homeless shelters, doctors, hospitals, public health departments, supervised visitation centers, lawyers, prosecutors, probation officers, child welfare workers, mental health and substance abuse providers, batterer intervention programs, schools, universities, day care centers, animal control, faith-based communities, and child death review teams.

Any of these entities may have the opportunity to offer assistance to victims through direct services or appropriate referrals. These agencies also have opportunities to offer services to batterers and ensure batterer accountability. The same collaboration that occurs among agencies when they are conducting domestic violence fatality reviews should occur at the front end to help prevent homicides.

Communities should focus, in particular, on increasing awareness among victims and the community of available services offered by certified domestic violence centers. Domestic violence centers save lives. There are 42 certified centers in the state and most have outreach offices. Domestic violence centers provide confidential shelter to victims and their families. They also provide a wide range of services including legal advocacy, empowerment advocacy, mental health and substance abuse referrals, children's programs, employment and housing assistance, and guidance re: immigration issues. These services are available to survivors and their families at no charge.

Additionally, agencies should collaborate to

- Promote training and cross training, including broad cultural competency guidance, so service providers better understand the needs of domestic violence victims and perpetrators, and better understand each other's work.

- Coordinate the activities of the many agencies involved in providing assistance to victims of domestic violence or investigating domestic violence homicide, to share and exchange information regarding challenges and successes.
- Increase awareness and education of men, who are the majority of domestic violence perpetrators in the state, to advocate against domestic violence.
- Increase awareness among clergy/faith-based communities. Fatality reviews have revealed that many victims seek advice and counsel from clergy about abuse.
- Increase awareness among youth and teens, through education in schools and other prevention programs.
- Seek input from survivors on what they view as gaps in the system and what types of services are most helpful to them, through FCADV's survivor listening groups, or other methods.

## **Recommendation 2**

FCADV and the Domestic Violence Program Office of DCF should continue to collaborate to identify funding sources and other resources to provide technical assistance, training, standards, and guidance to local fatality review teams. This will enable teams to expand the scope of cases reviewed and examine systems beyond criminal justice, such as medical, mental health, and child welfare, and examine family dynamics beyond domestic violence. Such examinations will provide a more complete picture of the family and allow teams to view the system and services “through the eyes of the victim.”

Technical assistance and support includes:

- Assisting communities that do not currently have fatality review teams in forming a team.
- Developing a tool to collect meaningful information from local fatality review teams, analyzing the data, and issuing a yearly report identifying trends statewide that will assist communities in preventing domestic violence homicides.
- Identifying entities statewide that have information that might be relevant to domestic violence fatality review but are not traditional “players” in fatality review.
- Developing protocols and standards addressing the challenges of data sharing among agencies.
- Assisting local teams in expanding membership to bring more people to the table as team members, including survivors and members of the clergy and expanding the scope of inquiry to include increased focus on perpetrators.
- Encouraging local fatality review teams to do more in-depth reviews of fewer cases (if necessary), that involve interviews with persons who are closest to the victim and the perpetrator who often have the most information about the case. Provide guidance to

- local teams on how to conduct these in-depth reviews, including protocols for reaching out to families, effective and compassionate interview techniques, and information on cultural diversity and its influence on responses to domestic violence.
- Developing recommendations for linking information gathered in fatality reviews with other statewide efforts, including coordinated community response, and training responders in risk assessment.
  - Encouraging local review teams to include in their review an assessment of dangerousness markers to determine whether or not a lethality assessment in a particular case would have been useful.
  - Assisting interested local fatality review teams in expanding their reviews to include additional categories of fatalities including: murder/suicide, perpetrator killing new partner/paramour of victim, victim suicides, killing of victim's children or other family members, killing of victim's friends or fellow employees at a workplace, bystander deaths, including neighbors and police officers and near-deaths. Developing definitions of these cases and recommendations/protocols to guide local teams in determining whether they want to expand the scope of review, and in identifying and reviewing these cases.
  - Establishing a forum for communication between local fatality review teams, such as a listserv.
  - Conducting additional statewide training events on domestic violence fatality review. The 150 people attending the two trainings funded by this grant demonstrate the need for and strong interest in additional statewide trainings coordinated by FCADV, when appropriate funding is available to do so.

### **Recommendation 3**

The legislature should amend Section 741.316, Fla. Stat., to protect members of fatality review teams from subpoena in criminal cases in the same way that Florida law protects members of child abuse death review teams.

Section 741.316(6), Fla. Stat., states that:

All information and records acquired by a domestic violence fatality review team are not subject to discovery or introduction into evidence in any civil action or disciplinary proceeding by any department or employing agency if the information or records arose out of matters that are the subject of evaluation and review by the domestic violence fatality review team. However, information, documents, and records otherwise available from other sources are not immune from discovery or introduction into evidence solely because the information, documents, or records were presented to or reviewed by such a team. A person who has attended a meeting of a domestic violence fatality review team may not testify in any civil or disciplinary proceedings as to any records or information produced or presented to the team during meetings or other activities authorized by this section. This subsection does not preclude any person who testifies before a team or who is a member of a team from testifying as to matters otherwise within his or her knowledge.

In contrast, members of Florida's child abuse death review teams currently are protected from subpoena in both civil and criminal cases. Section 383.402(14), Fla. Stat. provides:

A person who has attended a meeting of the state committee or a local committee or who has otherwise participated in activities authorized by this section may not be permitted or required to testify in any civil, criminal, or administrative proceeding as to any records or information produced or presented to a committee during meetings or other activities authorized by this section. However, this subsection does not prevent any person who testifies before the committee or who is a member of the committee from testifying as to matters otherwise within his or her knowledge. An organization, institution, committee member, or other person who furnishes information, data, reports, or records to the state committee or a local committee is not liable for damages to any person and is not subject to any other civil, criminal, or administrative recourse. This subsection does not apply to any person who admits to committing a crime.

Local domestic violence fatality review teams generally do not begin their reviews until after the final disposition of a related criminal case, including the appeal, because of the possibility they could be subpoenaed to testify at the criminal trial. Consequently, fatality reviews often are not conducted until years after the homicide, with the result that key information, and key people,

are lost with the passage of time. If domestic violence fatality review team members are protected from subpoenas in criminal cases, the teams may begin their reviews sooner, resulting in timelier and more meaningful reviews. Additionally, protection from subpoenas would also encourage more frequent reviews of near death cases, which are invaluable because of the benefit of input from the victim.

# APPENDIX

Florida Fatality Review Statutes .....	1
Domestic Violence Fatality Review Statewide Steering Committee Member List.....	2
Electronic Newsletters .....	3
Local Fatality Review Teams.....	4

APPENDIX 1

*Florida Fatality Review  
Statutes*

## Florida Statutes (2009)

### **741.316 Domestic violence fatality review teams; definition; membership; duties; report by the Department of Law Enforcement.--**

(1) As used in this section, the term “domestic violence fatality review team” means an organization that includes, but is not limited to, representatives from the following agencies or organizations:

- (a) Law enforcement agencies.
- (b) The state attorney.
- (c) The medical examiner.
- (d) Certified domestic violence centers.
- (e) Child protection service providers.
- (f) The office of court administration.
- (g) The clerk of the court.
- (h) Victim services programs.
- (i) Child death review teams.
- (j) Members of the business community.
- (k) County probation or corrections agencies.
- (l) Any other persons who have knowledge regarding domestic violence fatalities, nonlethal incidents of domestic violence, or suicide, including research, policy, law, and other matters connected with fatal incidents.
- (m) Other representatives as determined by the review team.

(2) A domestic violence fatality review team may be established at a local, regional, or state level in order to review fatal and near-fatal incidents of domestic violence, related domestic violence matters, and suicides. The review may include a review of events leading up to the domestic violence incident, available community resources, current laws and policies, actions taken by systems and individuals related to the incident and the parties, and any information or action deemed relevant by the team, including a review of public records and records for which public records exemptions are granted. The purpose of the teams is to learn how to prevent domestic violence by intervening early and improving the response of an individual and the system to domestic violence. The structure and activities of a team shall be determined at the local level. The team may determine the number and type of incidents it wishes to review and shall make policy and other recommendations as to how incidents of domestic violence may be prevented.

(3) The Governor’s Task Force on Domestic Violence shall provide information and technical assistance to local domestic violence fatality review teams.

(4)(a) There may not be any monetary liability on the part of, and a cause of action for damages may not arise against, any member of a domestic violence fatality review team or any person acting as a witness to, incident reporter to, or investigator for a domestic violence fatality review team for any act or proceeding undertaken or performed within the scope of the functions of the team, unless such person acted in bad faith, with malicious purpose, or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

(b) This subsection does not affect the provisions of s. 768.28.

(5) All information and records acquired by a domestic violence fatality review team are not subject to discovery or introduction into evidence in any civil action or disciplinary proceeding by any department or employing agency if the information or records arose out of matters that are the subject of evaluation and review by the domestic violence fatality review team. However, information, documents, and records otherwise available from other sources are not immune from discovery or introduction into evidence solely because the information, documents, or records were presented to or reviewed by such a team. A person who has attended a meeting of a domestic violence fatality review team may not testify in any civil or disciplinary proceedings as to any records or information produced or presented to the team during meetings or other activities authorized by this section. This subsection does not preclude any person who testifies before a team or who is a member of a team from testifying as to matters otherwise within his or her knowledge.

(6) The domestic violence fatality review teams are assigned to the Department of Children and Family Services for administrative purposes.

**History.**--s. 1, ch. 2000-220; s. 2, ch. 2008-112.

**Florida Statutes (2009)**

**741.3165 Certain information exempt from disclosure.--**

(1)(a) Any information that is confidential or exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution and that is obtained by a domestic violence fatality review team conducting activities as described in s. 741.316 shall retain its confidential or exempt status when held by a domestic violence fatality review team.

(b) Any information contained in a record created by a domestic violence fatality review team pursuant to s. 741.316 that reveals the identity of a victim of domestic violence or the identity of the children of the victim is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(2) Portions of meetings of any domestic violence fatality review team regarding domestic violence fatalities and their prevention, during which confidential or exempt information, the identity of the victim, or the identity of the children of the victim is discussed, are exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15, and shall stand repealed on October 2, 2010, unless reviewed and saved from repeal through reenactment by the Legislature.

**History.--**s. 1, ch. 2000-219; s. 1, ch. 2005-212; s. 160, ch. 2008-4.

APPENDIX 2

*Domestic Violence Fatality  
Review Statewide Steering  
Committee Member List*

**FATALITY REVIEW STATEWIDE STEERING COMMITTEE  
MEMBER LIST**

Trula Motta  
Office of Domestic Violence Programs  
Florida Department of Children and Families

Ed Hardy  
Director of Criminal Justice Services  
Florida Department of Children and Families

Hans Soder  
Operations/Child Location  
Florida Department of Children and Families

Jean Itzin, Bureau Chief  
Florida Department of Law Enforcement

Roy Hudson  
Director of Law Enforcement Services  
Florida Sheriffs Association

Tom Barry, Commander  
Titusville Police Department

Teresa Drake, Esq.  
Division Chief, County Court  
Office of the State Attorney, 8<sup>th</sup> Judicial Circuit

Christina Harris, Bureau Chief  
Office of the Attorney General

Rose Patterson, Esq.  
Chief of Court Improvement  
Office of the State Courts Administrator

Donna Fagan, Executive Director  
Another Way, Inc. Certified Domestic Violence Center

Angela Diaz-Vidaillet, Executive Director  
The Lodge/Victims Response, Inc. Certified Domestic Violence Center

Gria Davison  
School Social Work Consultant  
Florida Department of Education

Mark Lazarus, Administrator  
Victim Assistance Program Office  
Florida Department of Corrections

Mark Broderick, Director of Civil Court Operations  
Clerk and Comptroller's Office  
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Nerissa Carter, Executive Director  
Knowledge Is Power

Nancy Slater, Program Manager  
Medical Examiner's Office  
Rockledge, FL

Tonya Shepherd, Deputy Chief of DV Unit  
Office of the State Attorney  
15<sup>th</sup> Judicial Circuit

Michael Haney, Ph.D., NCC, LMHC  
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Florida Department of Health

Agnese Capps  
DV Program Coordinator  
Fourth Judicial Circuit

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Unified Family Court  
Eleventh Judicial Circuit

Joe Lobianco, Supervisor  
Child Protective Investigations  
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St. John's County Local Fatality Review Team  
St. Augustine, FL

Mary Beth Copeland  
Public Representative  
Jacksonville, FL

Cherie Simmers  
Director of Agency Relations  
Community Foundation of Greater Lakeland

Nina Zollo, Esq. (Chair)  
Vice President of Legal and Policy  
Florida Coalition Against Domestic Violence  
Tallahassee, FL

APPENDIX 3

*Electronic Newsletters*

## **FLORIDA DOMESTIC VIOLENCE FATALITY REVIEW E-NEWSLETTER**

**Number 1    June 2008**

### **The Department of Children and Families and the Florida Coalition Against Domestic Violence Create Statewide Domestic Violence Fatality Review Team**

The Department of Children and Families (DCF) has received an award from the Grants to Encourage Arrest Policies and Enforcement of Protection Orders Program, administered by the Department of Justice, to partner with the Florida Coalition Against Domestic Violence (FCADV) to create a statewide domestic violence fatality review team. The two year grant will enable the statewide team to meet four times to:

- Identify gaps in service delivery to domestic violence victims and identify potential systemic breakdowns.
- Promote training and cross-training to professionals
- Coordinate the activities of agencies involved and share and exchange information.

The team will prepare a comprehensive report at the end of the grant period that contains findings and recommendations relating to domestic violence fatality review. Through this grant, FCADV will also offer two training institutes on fatality review issues, conducted by national and local experts, establish a web page dedicated to fatality review, and distribute an E-Newsletter. The first training institute will be held in the fall of 2008 in South Florida.

The initial meeting of the statewide team was held on May 29, 2008 in Tallahassee, Florida. Representatives of DCF, FCADV, the Department of Corrections, the Office of the Attorney General, the Sheriff's and Police Chiefs Associations, the state attorney, domestic violence centers, batterer's intervention programs, the Office of State Court Administration, the Florida Department of Law Enforcement, and local fatality review teams discussed for three hours the challenges relating to domestic violence fatality review on both the statewide and local levels. The members identified four additional long-term goals for the statewide team during the grant period:

- Develop a tool to collect meaningful statewide data from local fatality review teams relating to domestic violence fatalities and near fatalities
- Establish a statewide fatality review team that will provide technical assistance, standards, and guidance to local fatality review teams, and assist the local teams in obtaining funding to continue their work
- Prepare a final report that identifies trends and provides individual guidance to each stakeholder in the effort to prevent domestic violence fatalities
- Develop a statewide public awareness campaign about domestic violence that targets all ages and cultural backgrounds

## **Florida's Local Fatality Review Teams**

There are currently 15 active, or about to be active local domestic violence fatality review teams in Florida. Representatives from the teams from Miami-Dade, Palm Beach, Polk and Highlands, Duval, and the Third Judicial Circuit (Columbia, Madison, Taylor, Dixie, Lafayette, Hamilton and Suwannee Counties) attended the initial statewide meeting, and reported on their structure and the types of cases they review. The reports from the local teams emphasized the differences in the operations of the various teams, as well as the differences in their funding. For example, the Miami-Dade team is funded by the county, and has full-time staff devoted to domestic violence fatality review. Other teams rely on volunteers from the various agencies to conduct the review.

Teams are currently active in the following counties: Brevard, Broward, Columbia (including Madison, Taylor, Dixie, Lafayette, Hamilton and Suwannee), Duval, Escambia, Lee, Miami-Dade, Orange, Palm Beach, Pasco, Pinellas, Polk (including Highlands), Sarasota (including Manatee and DeSoto). New teams are scheduled to start meeting this year in Hillsborough and Seminole counties.

Local fatality review teams are governed by Chapter 741, Florida Statutes. The statutes define a domestic violence fatality review team, and provide guidance on membership and the types of cases reviewed by the team.

### **741.316 Domestic violence fatality review teams; definition; membership; duties; report by the Department of Law Enforcement.--**

(1) As used in this section, the term "domestic violence fatality review team" means an organization that includes, but is not limited to, representatives from the following agencies or organizations:

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- (e) Child protection service providers.
- (f) The office of court administration.
- (g) The clerk of the court.
- (h) Victim services programs.
- (i) Child death review teams.

(j) Members of the business community.

(k) County probation or corrections agencies.

(l) Any other persons who have knowledge regarding domestic violence fatalities, nonlethal incidents of domestic violence, or suicide, including research, policy, law, and other matters connected with fatal incidents.

(m) Other representatives as determined by the review team.

(2) A domestic violence fatality review team may be established at a local, regional, or state level in order to review fatal and near-fatal incidents of domestic violence, related domestic violence matters, and suicides. The review may include a review of events leading up to the domestic violence incident, available community resources, current laws and policies, actions taken by systems and individuals related to the incident and the parties, and any information or action deemed relevant by the team, including a review of public records and records for which public records exemptions are granted. The purpose of the teams is to learn how to prevent domestic violence by intervening early and improving the response of an individual and the system to domestic violence. The structure and activities of a team shall be determined at the local level. The team may determine the number and type of incidents it wishes to review and shall make policy and other recommendations as to how incidents of domestic violence may be prevented.

(3) Each local domestic violence fatality review team shall collect data regarding incidents of domestic violence. The data must be collected in a manner that is consistent statewide and in a form determined by the Department of Law Enforcement. Each team may collect such additional data beyond that which is prescribed in the statewide data collection form as will assist in the team's review. The Department of Law Enforcement shall use the data to prepare an annual report concerning domestic violence fatalities. The report must be submitted by July 1 of each year to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Chief Justice of the Supreme Court.

(4) The Governor's Task Force on Domestic Violence shall provide information and technical assistance to local domestic violence fatality review teams.

(5)(a) There may not be any monetary liability on the part of, and a cause of action for damages may not arise against, any member of a domestic violence fatality review team or any person acting as a witness to, incident reporter to, or investigator for a domestic violence fatality review team for any act or proceeding undertaken or performed within the scope of the functions of the team, unless such person acted in bad faith, with malicious purpose, or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

(b) This subsection does not affect the provisions of s. 768.28.

(6) All information and records acquired by a domestic violence fatality review team are not subject to discovery or introduction into evidence in any civil action or disciplinary proceeding by any department or employing agency if the information or records arose out of matters that are the subject of evaluation and review by the domestic violence fatality review team. However, information, documents, and records otherwise available from other sources are not immune from discovery or

introduction into evidence solely because the information, documents, or records were presented to or reviewed by such a team. A person who has attended a meeting of a domestic violence fatality review team may not testify in any civil or disciplinary proceedings as to any records or information produced or presented to the team during meetings or other activities authorized by this section. This subsection does not preclude any person who testifies before a team or who is a member of a team from testifying as to matters otherwise within his or her knowledge.

(7) The domestic violence fatality review teams are assigned to the Department of Children and Family Services for administrative purposes.

#### **741.3165 Certain information exempt from disclosure.--**

(1)(a) Any information that is confidential or exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution and that is obtained by a domestic violence fatality review team conducting activities as described in s. 741.316 shall retain its confidential or exempt status when held by a domestic violence fatality review team.

(b) Any information contained in a record created by a domestic violence fatality review team pursuant to s. 741.316 that reveals the identity of a victim of domestic violence or the identity of the children of the victim is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(2) Portions of meetings of any domestic violence fatality review team regarding domestic violence fatalities and their prevention, during which confidential or exempt information, the identity of the victim, or the identity of the children of the victim is discussed, are exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.

(3) This section is subject to the Open Government Sunset Review Act of 1995 in accordance with s. 119.15, and shall stand repealed on October 2, 2010, unless reviewed and saved from repeal through reenactment by the Legislature.

## **RESOURCES**

Florida Department of Law Enforcement Domestic Violence Fatality Review Team 2007 Annual Report <http://www.fdle.state.fl.us/>

Florida's Domestic Violence Needs Assessment for 2006-2007, Institute for Family Violence Studies, Florida State University

<http://www.dcf.state.fl.us/domesticviolence/publications/dvna0607final.pdf>

This project was supported by Grant No. 2007-WE-AX-0055 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women or the Florida Department of Children and Families.

## **FLORIDA DOMESTIC VIOLENCE FATALITY REVIEW E-NEWSLETTER**

**Number 2    December 2008**

The Department of Children and Families (DCF) has received an award from the Grants to Encourage Arrest Policies and Enforcement of Protection Orders Program, administered by the Department of Justice, to partner with the Florida Coalition Against Domestic Violence (FCADV) to create a statewide domestic violence fatality review team. The two year grant will enable the statewide team to meet four times and to sponsor two statewide fatality review training institutes for local fatality review teams and other members of the community.

### **National Experts to Serve as Project Consultants**

Dr. Neil Websdale and Matthew Dale, national experts on domestic violence fatality review, have agreed to serve as consultants to Florida's statewide team. As project consultants, they will also develop the curriculum for and conduct two statewide domestic violence fatality review trainings tentatively set for April and September, 2009.

Dr. Websdale is Professor of Criminal Justice at Northern Arizona University and Principal Project Advisor to and former Director of the National Domestic Violence Fatality Review Initiative. He has published work on domestic violence, the history of crime, policing, social change, and public policy. Dr. Websdale has published four books including: *Rural Woman Battering and the Justice System: An Ethnography* (Sage Publications), 1998, which won the Academy of Criminal Justice Sciences Outstanding Book Award in 1999; *Understanding Domestic Homicide* (Northeastern University Press), 1999; *Making Trouble: Cultural Constructions of Crime, Deviance, and Control* (Aldine Books, co-edited with Jeff Ferrell), 1999; and *Policing the Poor: From Slave Plantation to Public Housing* (Northeastern University Press), 2001, winner of the Academy of Criminal Justice Sciences Outstanding Book Award in 2002 and the Gustavus-Myers Center for the Study of Bigotry and Human Rights Award in 2002. He is currently working on a book tentatively entitled *Familicidal Hearts*, due to be published by Oxford University Press in 2008. His social policy work consists of helping establish a national network of domestic violence fatality review teams. He has also worked on issues related to community policing, full faith and credit, and risk assessment and management in domestic violence cases.

In October 2001, Montana Attorney General Mike McGrath appointed Matthew Dale as the first-ever Director of the Department of Justice's (DOJ) Office of Consumer Protection and Victim Services (OCPVS). In this position, Mr. Dale coordinates work around the state in the areas of dating violence, consumer protection, sexual assault and domestic violence. A key goal of the office is to consolidate and focus various programs within DOJ under a single management structure. Mr. Dale's work in the area of family violence includes staffing the MT Domestic Violence Fatality Review Team. This group of professionals visits communities that have experienced a recent death as a result of family violence. Team members work with their counterparts in the affected community (law enforcement, victim services, tribal governments, clergy, medical providers, CPS, batterers' treatment, courts, etc.) to identify gaps in services in an attempt to prevent future homicides. Mr. Dale has also served as a senior consultant for the National Domestic Violence Fatality Review Initiative and has given numerous presentations across the country on fatality review. He has published in the *Fatality Review Bulletin* and the journal *Violence Against Women*.

## **Second Meeting of Statewide Fatality Review Team**

The statewide team held its second meeting in Tallahassee on November 18, 2008. In attendance were representatives of DCF, FCADV, the Department of Corrections, the Office of the Attorney General, the Sheriff's and Police Chiefs Associations, the Florida Prosecuting Attorneys Association, the Department of Health, the Office of State Court Administration, the Florida Department of Law Enforcement, the Department of Education, the child death review team, domestic violence centers, batterer's intervention programs, medical examiner, a survivor of domestic violence, and local fatality review teams.

Project consultants Dr. Neil Websdale and Matthew Dale facilitated the team's discussion at the meeting. The team identified the following general trends in Florida, which track trends nationally:

- The majority of domestic violence homicide victims did not call law enforcement for assistance prior to their deaths
- The majority of domestic violence homicide victims did not receive services from a domestic violence center
- The majority of domestic violence homicide perpetrators were not previously involved with law enforcement

The team members identified and discussed possible gaps in law enforcement, civil and criminal court, social services, education, and other systems in Florida that contribute to these trends.

Team members also discussed ideas for outreach to address prevention of domestic violence. The team identified the following populations as targets for outreach. Representatives of these groups also should be members of domestic violence fatality review teams:

- Women. They are the majority of domestic violence victims, and they should be the primary focus of outreach. Women need to hear that there are services available to help them.
- Men. The majority of perpetrators are male and it is necessary to bring men into the domestic violence advocacy movement and educate them to prevent domestic violence.
- Clergy/Faith Base communities: Research suggests that domestic violence victims did seek support from clergy.
- Youth/Teens, through education in schools.

Members also discussed the role of a statewide domestic violence fatality review team, and how the statewide team could assist local fatality review teams. The consensus was that the statewide team should provide technical assistance and guidance to local fatality review teams in a number of ways. The statewide team will seek survey responses from local fatality review teams to help guide the curriculum for the two training institutes in 2009.

The FCADV Fatality Review webpage is at, <http://www.fcadv.org/projects-fatality.php>

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## **FLORIDA DOMESTIC VIOLENCE FATALITY REVIEW E-NEWSLETTER**

**Number 3    March 2009**

The Department of Children and Families (DCF) has received an award from the Grants to Encourage Arrest Policies and Enforcement of Protection Orders Program, administered by the Department of Justice, to partner with the Florida Coalition Against Domestic Violence (FCADV) to create a statewide domestic violence fatality review team. The two year grant will enable the statewide team to meet four times and to sponsor two statewide fatality review training institutes for local fatality review teams and other members of the community.

### **First Fatality Review Training Institute Set**

Dr. Neil Websdale and Matthew Dale, national experts on domestic violence fatality review, will conduct a one-day training on domestic violence fatality review on April 6, 2009, at Amelia Island Plantation. Dr. Websdale, Professor of Criminal Justice at Northern Arizona University and Principal Project Advisor to and former Director of the National Domestic Violence Fatality Review Initiative, and Mr. Dale, director of the Montana Department of Justice's Office of Consumer Protection and Victim Services, will present on current national trends in domestic violence fatality review, and will lead attendees in case studies to demonstrate effective fatality review techniques. Members of local fatality review teams, domestic violence advocates, law enforcement, criminal justice personnel, child welfare workers, the faith-based community, and health and family service providers are encouraged to attend. Scholarships are available for a limited number of certified domestic violence center advocates and members of local fatality review teams in Florida who are outside the Jacksonville area, to assist with hotel and travel expenses. Registration information is available at [www.fcadv.org](http://www.fcadv.org)

### **Dr. Nancy S. Hardt to Speak at April 6 Meeting of Statewide Fatality Review Team**

The statewide fatality review team will hold its third meeting on April 6, 2009 at Amelia Island Plantation. Dr. Nancy S. Hart, who has a strong interest in collaboration among state agencies to address and prevent domestic violence, will present on maternal death due to trauma in Florida. Dr. Hardt is a Professor of Pathology and Obstetrics and Gynecology at the University of Florida College of Medicine and serves as the Senior Associate Dean for External Affairs. In this role she fosters collaborations with community leaders and participates in state and federal government affairs.

### **National Teen Dating Violence Awareness and Prevention Week**

The United States Congress declared February 2-6, 2009 National Teen Dating Violence Awareness and Prevention Week, to help end teen dating violence. Between 1993 and 1999, 22% of all homicides against females ages 16-19 were committed by an intimate partner. Bureau of Justice Statistics Press Release, "Violence Rates Among Intimate Partners Differ Greatly According to Age," (10/29/01).

## **Important Facts About Teen Dating Violence**

Nearly three in four tweens (72%) say boyfriend/girlfriend relationships usually begin at age 14 or younger. (Liz Claiborne Inc. study on teen dating abuse conducted by Teenage Research Unlimited, February 2008.)

62% of tweens (age 11-14) who have been in a relationship say they know friends who have been verbally abused (called stupid, worthless, ugly, etc) by a boyfriend/girlfriend. (Liz Claiborne Inc. study on teen dating abuse conducted by Teenage Research Unlimited, February 2008.)

Only half of all tweens (age 11-14) claim to know the warning signs of a bad/hurtful relationship. (Liz Claiborne Inc. study on teen dating abuse conducted by Teenage Research Unlimited, February 2008.)

More than three times as many tweens (20%) as parents (6%) admit that parents know little or nothing about the tweens' dating relationships. (Liz Claiborne Inc. study on teen dating abuse conducted by Teenage Research Unlimited, February 2008.)

1 in 3 teenagers report knowing a friend or peer who has been hit, punched, kicked, slapped, choked or physically hurt by their partner. (Liz Claiborne Inc. study on teen dating abuse conducted by Teenage Research Unlimited, February 2005.)

Nearly 1 in 5 teenage girls who have been in a relationship said a boyfriend had threatened violence or self-harm if presented with a break-up. (Liz Claiborne Inc. study on teen dating abuse conducted by Teenage Research Unlimited, February 2005.)

13% of teenage girls who said they have been in a relationship report being physically hurt or hit. (Liz Claiborne Inc. study on teen dating abuse conducted by Teenage Research Unlimited, February 2005.)

1 in 4 teenage girls who have been in relationships reveal they have been pressured to perform oral sex or engage in intercourse. (Liz Claiborne Inc. study on teen dating abuse conducted by Teenage Research Unlimited, February 2005.)

More than 1 in 4 teenage girls in a relationship (26%) report enduring repeated verbal abuse. (Liz Claiborne Inc. study on teen dating abuse conducted by Teenage Research Unlimited, February 2005.)

80% of teens regard verbal abuse as a "serious issue" for their age group. (Liz Claiborne Inc. study on teen dating abuse conducted by Teenage Research Unlimited, February 2005.)

If trapped in an abusive relationship, 73% of teens said they would turn to a friend for help; but only 33% who have been in or known about an abusive relationship said they have told anyone about it. (Liz Claiborne Inc. study on teen dating abuse conducted by Teenage Research Unlimited, February 2005.)

Twenty-four percent of 14 to 17-year-olds know at least one student who has been the victim of dating violence, yet 81% of parents either believe teen dating violence is not an issue or admit they don't know if it is an issue. (Survey commissioned by the Empower Program, sponsored by Liz Claiborne Inc. and conducted by Knowledge Networks, Social Control, Verbal Abuse, and Violence Among Teenagers, December 2000)

Less than 25% of teens say they have discussed dating violence with their parents. (Liz Claiborne Inc. study of teens 13-17 conducted by Applied Research and Consulting LLC, Spring 2000)

89% of teens between the ages of 13 and 18 say they have been in dating relationships; forty percent of teenage girls age 14 to 17 report knowing someone their age who has been hit or beaten by a boyfriend. (Children Now/Kaiser Permanente poll, December 1995)

Nearly 80% of girls who have been physically abused in their intimate relationships continue to date their abuser. (City of New York, Teen Relationship Abuse Fact Sheet, March 1998)

### **Teen Dating Violence Resources**

#### **Break the Cycle**

[www.breakthecycle.org](http://www.breakthecycle.org)

Break the Cycle is a nonprofit organization whose mission is to engage, educate and empower youth to build lives and communities free from dating and domestic violence. They provide preventive education, free legal services, advocacy and support for young people between the ages of 12 to 22.

#### **Love is Not Abuse**

[www.loveisnotabuse.com](http://www.loveisnotabuse.com)

In response to a 2006 teen dating abuse survey, Liz Claiborne Inc. partnered with the National Domestic Violence Hotline to officially launch [loveisrespect.org](http://loveisrespect.org), The National Teen Dating Abuse Helpline (NTDAH) in February 2007. NTDAH is a 24-hour national telephone helpline and website created to help teens experiencing dating abuse and parents concerned about their teens' relationships. So far, in 2007, the Helpline engaged in more than 6,118 telephone and chat contacts. In another attempt to fight and prevent teen dating abuse, Liz Claiborne Inc. partnered with the Education Development Center to develop the Love Is Not Abuse curriculum. The curriculum is designed to help teens and teachers identify the signs of abuse, prevent abuse and learn where to get help.

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## **FLORIDA DOMESTIC VIOLENCE FATALITY REVIEW E-NEWSLETTER**

**Number 4    June 2009**

The Department of Children and Families (DCF) has received an award from the Grants to Encourage Arrest Policies and Enforcement of Protection Orders Program, administered by the Department of Justice, to partner with the Florida Coalition Against Domestic Violence (FCADV) to create a statewide domestic violence fatality review team. The two year grant will enable the statewide team to meet four times and to sponsor two statewide fatality review training institutes for local fatality review teams and other members of the community.

### **First Fatality Review Training Institute A Success!**

Dr. Neil Websdale and Matthew Dale, national experts on domestic violence fatality review, conducted a one-day training on domestic violence fatality review on April 6, 2009, in Jacksonville, Florida. Dr. Websdale, Professor of Criminal Justice at Northern Arizona University and Principal Project Advisor to and former Director of the National Domestic Violence Fatality Review Initiative, and Mr. Dale, director of the Montana Department of Justice's Office of Consumer Protection and Victim Services, presented to over 70 attendees representing local fatality review teams, domestic violence centers, law enforcement, criminal justice personnel, child welfare workers, and health and family service providers. Topics included current national trends in domestic violence fatality review, and attendees participated in mock fatality reviews of case studies based on actual domestic violence homicides.

### **University of Florida's Dr. Nancy S. Hardt Presented Research to the Statewide Fatality Review Team**

The statewide fatality review team held its third meeting on April 6, 2009 in Jacksonville. Fourteen members attended. Dr. Nancy S. Hardt, Professor of Pathology and Obstetrics and Gynecology at the University of Florida College of Medicine, presented her research on maternal death due to trauma in Florida, and its relationship to domestic violence fatalities. Her presentation resulted in much discussion among team members regarding the types of data that may be helpful to fatality reviews, and possible future collaborations.

### **Save the Dates**

The second DCF/ FCADV Fatality Review Training Institute is set for Friday, August 21, 2009, from 8:30 am – 4:00 pm at the Harbor Beach Marriott Resort, 3030 Holiday Drive, Ft. Lauderdale, Florida. The Office of State Court Administration (OSCA) hopes to co-sponsor this training. Dr. Neil Websdale and Matthew Dale will conduct the identical training held in Jacksonville in April. Topics will include current national trends in domestic violence fatality review, and attendees will participate in mock fatality reviews based on actual cases. Registration information will be posted on the Fatality Review Webpage in FCADV's website, <http://www.fcadv.org/projects-fatality.php>.

The final meeting of the Statewide Fatality Review Team is set for Thursday, August 20, from 1:00 pm – 5:00 pm, at the Harbor Beach Marriott Resort in Ft. Lauderdale, Florida.

### **Local Fatality Review Teams Respond to Survey**

The following are the results of a survey regarding the recent activity of and types of cases reviewed by local fatality review teams in Florida during 2008-2009. DCF and FCADV acknowledge the hard work of and critical role played by these local fatality review teams. Thanks to all local teams that responded to this survey.

**Brevard County's** team reviews homicides and homicide-suicides. The team reviewed three cases in 2008 and one thus far in 2009.

**Broward County's** team reviewed two murder-suicides in 2008. The team reviews homicide-suicides and homicide-near death cases.

**Duval County** reviews homicides and homicide-suicides of intimate partners. The team reviewed 10 cases in 2008.

**Hillsborough County's** team reviews intimate partner homicides. The team reviewed four cases in 2008 and four cases thus far in 2009.

**Miami-Dade County** reviews approximately two cases per month and reviews the following types of cases:

- Familiar DV-Related Deaths
- Sexual Competitors
- Mercy Killing
- DV-Related Suicides
- DV-Related Near Death Victims
- Child Abuse/Neglect Deaths

**Palm Beach County** reviewed 4 homicide-suicide cases. The team reviews the following types of cases in attempt to address the question of intervention precluding serious injury or death such as:

- Near Fatal/Attempt Murder
- Domestic/Intimate Partner
- Same Sex/Significant Other
- Dating Relationships – Aggravated Battery/Attempt Murder
- Presentation of some Domestic Homicides perpetrated outside of the County

**Pasco County** reviews homicide-suicides, suicide-near-death, and cases where the perpetrator attacked the child or attacked the victim's new partner.

**Pinellas County** conducted 6 reviews in 2008 and 20 reviews so far in 2009. The team reviews intimate partner near fatalities, intimate partner homicide/suicide; multiple intimate partner and

children homicide/suicide (the perpetrator killed woman, her new partner, the two children, and then himself), and intimate partner homicides.

**Polk/Highlands Counties** reviewed three cases: an intimate partner homicide, a murder suicide, and a case where an ex-girlfriend and her new boyfriend killed ex-boyfriend; the ex-girlfriend and ex-boyfriend have a child in common.

**Santa Rosa County** is in the process of separating from the joint team for Escambia and Santa Rosa Counties, and plans to review its first case this October 2009. The team will focus on fatalities and near death or death/suicides cases only.

**Seminole County** plans to meet in June 2009 and then again in September with the intent of meeting quarterly. The team will be reviewing the nine domestic violence homicides that occurred in 2008.

**Alachua, Sarasota/Manatee and St. John's Counties** are in the process of forming/reactivating their fatality review teams and determining the types of cases they will review.

\* \* \*

Attached is a May 24, 2009 article from the **Palm Beach Post**, "State surge in child slayings may be another product of the recession" that discusses domestic violence fatalities.

\* \* \*

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# State surge in child slayings may be another product of the recession

By KATHLEEN CHAPMAN

Palm Beach Post Staff Writer

Sunday, May 24, 2009

The sad reports of babies killed by abuse - often by caretakers who shook them in frustration - seemed to be coming in more often, Department of Children and Families Secretary George Sheldon noticed in recent months.

A check of the numbers confirmed that 2008 was an unusually deadly year for Florida children. At least 35 died of traumatic injuries, up from 28 in 2007. And that number is expected to rise because the DCF is waiting for the final causes of death for 82 children.

## Danger at home

Overall numbers of domestic violence and child abuse reports have remained steady here and around the state, despite a rise in unemployment. But several experts say the anecdotal evidence shows a growing severity in the crimes:

- In 2008, Palm Beach County had 12 homicides because of domestic violence, the most in at least eight years.
- At least 35 children in Florida died of traumatic injuries in 2008, up from 28 in 2007.
- Florida's domestic violence centers have seen a jump in demand of more than 40 percent since last fall, the Florida Coalition Against Domestic Violence reported.

At the Palm Beach County Sheriff's Office, Sgt. Scott Shoemaker noticed a similar surge in violence. Twelve victims were killed by their abusers in 2008, making it "the worst year I can remember for domestic-related homicides," he said.

Domestic violence shelters around the state report that the number of women seeking help is up significantly.

Suzanne Turner, executive director for the YWCA of Palm Beach County, said she has seen a 60 percent increase in the number of women who want to leave a relationship but can't afford to relocate.

Family violence has always been an epidemic, Turner said. But she believes the strains of unemployment and foreclosure are making it even worse, laying bare the emotions that might once have been contained.

"It's the economy, no question about it," she said.

The wife who calls may be a lifelong stay-at-home mother, and the husband who worked for decades has been unemployed.

"He's depressed, and he's upset," she said. "The worries get a little higher and the voices get a little louder. ... Maybe there is long-standing emotional abuse that is now escalating to physical abuse."

The statistics paint a complex picture. Overall, reports of domestic violence and child abuse have not gone up in Florida or locally, even as the economy worsened.

In St. Lucie County, where unemployment is close to 13 percent, domestic violence calls went up between 2006 and 2007 but have been steady since then. Sheriff Ken Mascara said he believes the increase may be due to awareness campaigns rather than the economy.

But at least anecdotally, what might be different in this recession is the severity of that violence, often against women and children.

Shoemaker, who heads the sheriff's office's domestic violence unit, said the biggest trigger for homicides is the abuser's rage when a victim tries to leave, and the problem affects everyone from rich to poor. But in a review of last year's homicides, Shoemaker said, many of the families had financial problems as well.

"I think if you look at domestic violence in general, money is a big factor," Shoemaker said. "There is no question that couples are going to fight over finances, and with the economy the way it is, it's going to flare up."

In cases involving children, a parent's inexperience poses the greatest risk to an infant, Sheldon said. But the fact that the shaken-baby deaths have spiked as the economy worsens "is not, I believe, a coincidence," he said.

"You have a young kid who loses his job and can't pay the rent. It's 2 a.m., and he has an infant who won't stop crying," Sheldon said. Too often, instead of collecting themselves or walking away, young parents shake the baby in frustration, causing death or lifelong brain damage.

"I've seen more of those cases in the last six months than I saw in the first two years I was here," said Sheldon, who has been with the DCF since 2007.

Locally, the state agency is acting to combat both domestic violence and shaken-baby cases. The agency is reviewing cases, working with a variety of partners to find out the best way to help families affected by violence.

Palm Beach County's DCF also plans to work with other organizations on a public awareness campaign to teach people how to cope with the frustrations of parenting, especially during periods of "purple crying," when infants scream so intently that their faces turn purple.

It is important for parents to realize that they can walk away until they have a chance to calm down, Sheldon said.

"The more I talk to our folks in the field, the more I think this is something we've got to focus more public attention on."



**Find this article at:**

[http://www.palmbeachpost.com/search/content/local\\_news/epaper/2009/05/24/0524violence.html](http://www.palmbeachpost.com/search/content/local_news/epaper/2009/05/24/0524violence.html)

APPENDIX 4

*Local Fatality  
Review Teams*

**FLORIDA'S LOCAL DOMESTIC VIOLENCE  
FATALITY REVIEW TEAMS**

**Alachua:**

Teresa Drake  
Division Chief, County Court  
Office of the State Attorney, 8<sup>th</sup> Judicial Circuit  
120 West University Avenue  
Gainesville, FL 32601  
Phone: (352) 374-3670  
Email: [draket@sao8.org](mailto:draket@sao8.org)

**Brevard County:**

Lisa DeAnda (Chair)  
Office of the State Attorney  
2725 Judge Fran Jameson Way, Bldg. D  
Viera, FL 32940  
Phone: 321-617-7555  
Email: [lmister@sa18.state.fl.us](mailto:lmister@sa18.state.fl.us)

**Broward County:**

Nancy Tanner  
Victim Advocate Unit  
State Attorney's Office  
16 South East 6<sup>th</sup> Street  
Ft. Lauderdale, FL 33312  
(954) 765-4133  
Email: [ntanner@sao17.state.fl.us](mailto:ntanner@sao17.state.fl.us)

**Columbia County\*: (Third Judicial Circuit)**

Donna Fagan, Executive Director  
Another Way, Inc  
P.O. Box 1028  
Lake City, FL 32056-1028  
(386) 719-2757  
Email: [donnafagan@anotherwayinc.net](mailto:donnafagan@anotherwayinc.net)  
(Also reporting for Madison, Taylor, Dixie,  
Lafayette, Hamilton, and Suwannee Counties)

**Duval County:**

Agnese Capps  
DV Program Coordinator  
Family Court Services  
Duval County Cthse. Annex  
220 East Bay Street, Room 101  
Jacksonville, FL 32202  
Phone: (904) 630-1212, Ext. 3893  
Email: [acapps@coj.net](mailto:acapps@coj.net)

**Escambia County:**

Greg Marcille  
State Attorney's Office  
P.O. Box 12726  
Pensacola, FL 32575  
(850) 595-4200  
Email: [greg\\_marcille@co.escambia.fl.us](mailto:greg_marcille@co.escambia.fl.us)

**Hillsborough County:**

Nikki Daniels (Chair)  
Family Justice Center  
9309 North Florida Ave., Suite 109  
Tampa, FL 33612  
Phone: 813-490-9401  
Email: [ndaniels@fjchc.org](mailto:ndaniels@fjchc.org)

**Lee County:**

Jennifer Benton  
Abuse Counseling and Treatment, Inc.  
P.O. Box 60401  
Ft. Meyers, FL 33906  
(239) 939-2553  
Email: [jbenton@actabuse.com](mailto:jbenton@actabuse.com)

**Manatee**

Major Connie Shingledecker  
Investigative Bureau Chief  
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600 U.S. Hwy 301 Blvd. West, Suite 202  
Bradenton, FL 34205  
Phone: (941) 747-3011, Ext. 2241  
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Laurel Lynch, Exec. Director  
HOPE Family Services  
P. O. Box 1624  
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