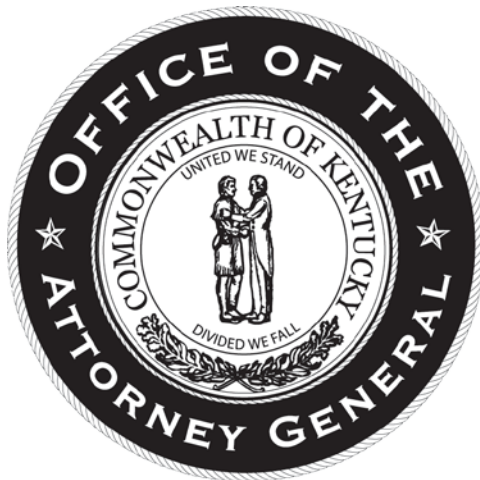


Domestic Violence Fatality Review

Data Report & Summation



DOMESTIC VIOLENCE FATALITY REVIEW DATA REPORT AND SUMMATION



**OFFICE OF THE ATTORNEY GENERAL
OFFICE OF VICTIMS ADVOCACY**

OCTOBER 2014

Table of Contents

<i>Executive Summary, Attorney General Jack Conway</i>	1
HISTORY OF DOMESTIC VIOLENCE LAWS AND SERVICES IN KENTUCKY	2
COMMENCEMENT AND SCOPE OF THE “SUMMIT”	4
Domestic Violence Fatality Review Efforts in Kentucky at the Time of the Summit	6
<i>Louisville and Jefferson County</i>	6
<i>Lexington and Fayette County</i>	7
METHODOLOGY	9
A STATE PLAN.	10
Objectives of Fatality Review.	10
Work and Results of the Summit Committees.	11
LEGISLATIVE UPDATES 2012-2013.	12
LIMITATIONS AND RECOMMENDATIONS	16
CREATING A FATALITY REVIEW TEAM IN YOUR COUNTY: <i>A Guide to Development of Policies and Model Policies</i>	17
“KEY DECISIONS TO GETTING STARTED”	18
<i>Appendix</i>	25
MODEL PROTOCOL FOR DOMESTIC VIOLENCE FATALITY REVIEW TEAM	A1
MODEL SIGN-IN / CONFIDENTIALITY STATEMENT.	A2
<i>Domestic Violence Fatality – Special Report – Kentucky 2010 Homicides.</i>	A3

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As we observe October as Domestic Violence Awareness Month, I am reminded of this horrific epidemic and its effects. In the Commonwealth alone, one in three women will be a domestic violence victim in her lifetime (KCHFS, 2006). While the statistics are staggering, my primary concern is the protection of our victims and their families and the prevention of domestic violence.

That's why I convened Kentucky's first statewide Summit on Domestic Violence Fatalities. This summit brought together experts from across the Commonwealth forming the *Statewide Domestic Violence Fatality Review Committee*. The goals of the summit were multifaceted including: development of a plan for collection and analysis of domestic violence fatalities in the Commonwealth, development of local domestic violence fatality review teams, and development of model policies and procedures to guide the work of the local teams.

The Statewide Domestic Violence Fatality Review Committee soon began to realize that Kentucky did not have the data needed to provide a clear picture of the extent and nature of domestic violence fatalities in the Commonwealth. Believing that such data was critical to guiding the future work of the committee, the members set as their first priority the development of a data collection tool to collect information about the domestic violence related deaths that occurred in Kentucky in 2010.

The collection of this data resulted in the publication of this Domestic Violence Fatality Special Report. I am confident that the information contained in this report will not only provide valuable information to guide the future work of the committee, but will also help advance our mission of preventing future domestic violence fatalities and preserving the safety of our victims throughout the Commonwealth.

Finally, I want to thank the members of the committee, especially Dr. TK Logan, for volunteering their time, and for their dedication to this initiative. Without their assistance this report would not have been possible.

Sincerely,

A handwritten signature in black ink that reads 'Jack Conway'. The signature is fluid and cursive, with the first name 'Jack' being larger and more prominent than the last name 'Conway'.

Jack Conway
Kentucky Attorney General

***HISTORY OF DOMESTIC VIOLENCE
LAWS AND SERVICES IN KENTUCKY***

Domestic Violence Fatality Review has the objectives of preventing domestic violence fatalities, preserving the safety of victims, holding accountable the perpetrators of domestic violence and creating collaborative efforts with multiple agencies and organizations. According to the Kentucky Coalition Against Domestic Violence, “KCADV,” “community awareness of the pervasiveness and severity of domestic violence in Kentucky heightened in the late 1970’s. The YWCA in Louisville opened Kentucky’s first spouse abuse shelter in 1977. By 1980 there were six shelter programs serving battered women and their children in Kentucky.¹” KCADV was founded in 1981 and by 1985 had reached its goals of having a domestic violence program in each of the Commonwealth’s Area Development Districts and a stable funding stream.

With services available across the Commonwealth, KCADV and other interested agencies, organizations and professionals began to advocate for changes in state laws. The focus of these changes was on increasing protection for and providing services and assistance to victims of domestic violence. Moreover, there was a need for improving the criminal justice system’s response to domestic violence including holding offenders accountable.

As a response, formal and informal multidisciplinary efforts for improving laws in the area of domestic violence soon followed. The collaborative efforts and initiatives from Attorney General Conway’s Task Force on Domestic Violence Crime, Kentucky’s Legislative Task Force on Domestic Violence, and the Governor’s Council on Domestic Violence and Sexual Assault led to many positive legislative changes. In 2002, these changes included the passage of legislation by the General Assembly specifically authorizing the creation of Domestic Violence Fatality Review Teams in local communities.²

Although much work had been done over the past four decades to address domestic violence, still more work remained. To continue and to further advance the idea and importance of domestic violence fatality review, Attorney General Conway convened Kentucky’s first statewide Summit on Domestic Violence Fatalities in August of 2011.

¹ <http://www.kdva.org/about/history.html>.

² KRS 403.750.

***COMMENCEMENT AND SCOPE
OF THE “SUMMIT”***

The Summit of 2011 brought the expertise of professionals from across the Commonwealth in the areas of domestic violence, domestic violence fatality review and data collection and analysis. The Summit invitees were: Lee Alcott, Executive Director, Barren River Area Safe Space, Inc.; Kim Allen, Louisville Metro Government; Honorable Jerry Bowles, Family Court Judge, Jefferson County; Secretary J. Michael Brown, Kentucky Justice and Public Safety Cabinet; Hon. Carol Cobb, Assistant Commonwealth Attorney, Jefferson County; Hon. Christopher Cohron, Commonwealth's Attorney, Warren County; Dr. Tracey Corey, Chief Medical Examiner; Sherry Currens, Executive Director, Kentucky Domestic Violence Association; Teri Faragher, Director, Lexington-Fayette County Domestic Violence Prevention Board; Jim Grace, Assistant Director, Cabinet for Health and Family Services, Department for Community Based Services, Division of Protection and Permanency (retired); Carol Jordan, Director, University of Kentucky Office for Policy Studies on Violence Against Women; Dr. TK Logan, Professor, Department of Behavioral Science, College of Medicine and Center on Drug and Alcohol Research, University of Kentucky; Lt. Carolyn Nunn, Commander, Special Victims Unit, Louisville Metro Police Department; Marcia Roth, Executive Director, Mary Byron Project; Dr. Sabrina Walsh, Assistant Professor, Department of Epidemiology, College of Public Health, University of Kentucky; Commissioner Pat Wilson, Cabinet for Health and Family Services, Department for Community Based Services (retired); Hon. Kathy Phillips, Assistant Commonwealth's Attorney, Fayette County; Hon. Michelle Snodgrass, Commonwealth's Attorney, Campbell County; Dr. Barbara Weakley Jones, Coroner, Jefferson County; and Honorable Jo Ann Wise, Family Court Judge (retired).

Attorney General Conway set forth goals of the Summit to discuss the establishment of a statewide domestic violence fatality review program in the Commonwealth, development of a plan for collection and analysis of domestic violence fatalities, development of local domestic violence fatality review teams, and the development of model policies and procedures to guide the work of the local teams.

To reach the long-term goals of the Summit, the participants divided into two committees: the research and data collection committee, and the protocol development committee.

DOMESTIC VIOLENCE FATALITY REVIEW EFFORTS IN KENTUCKY AT TIME OF THE SUMMIT

In 2011, Kentucky statutes did not specifically permit or prohibit statewide fatality review teams. *KRS 403.705* does, however, specifically authorize the establishment in any jurisdiction or group of counties local domestic violence coordinating councils. *KRS 403.705(5)* further provides that “local domestic violence coordinating councils may, if authorized by the local coroner or a medical examiner, create a domestic violence fatality review team, the purpose of which shall be to prevent future deaths and injuries related to domestic violence.”

Although *KRS 403.705* was enacted in 2000, only Louisville/Jefferson County and Lexington/Fayette County had established teams at the time the Summit was held.

Louisville and Jefferson County

In January 1996, the Jefferson County Fiscal Court enacted Ordinance No. 1, Series 1996 creating the Jefferson County Domestic Violence Prevention Coordinating Council. The Council was formed based on the prevalent need to address domestic violence and its effects in the community. To assist the Council with its work, the Mortality Review Committee (renamed the Fatality Review Committee in 2004) was created. In December 1996, a multi-agency, multidisciplinary group convened and reported on data stemming from a high profile domestic violence fatality that occurred in the city. Each member agency was required to sign a confidentiality agreement on behalf of the agency and its employees upon joining the team and each team member signed a confidentiality agreement at the beginning of each meeting. All team files and notes were kept in a locked location at the Criminal Justice Commission.

The purpose of the Louisville team is to identify areas and means by which to increase and enhance coordinated agency and community responses to domestic violence through a systems-review approach by conducting multidisciplinary and multi-agency examinations of domestic violence fatalities. The Louisville team identifies areas and means by which to increase and enhance coordinated agency and community responses to domestic violence through a systems-review multidisciplinary approach.

Its goals are focused on prevention, knowledge, accountability and systems improvement. The team adopted a “no blame or shame” philosophy. Individuals are not blamed or singled out, rather processes, systems and policies are reviewed and recommendations for improvements are made when necessary.

The Louisville team reviews both open and closed cases involving adults 18 years of age or older where either party resides within Louisville Metro or if the incident occurs in Louisville Metro regardless of the residence of the parties. Cases are reviewed within the fiscal year during which they occur and are identified for potential review through agency request for a review, Coroner or Medical Examiner reports, media reports or obituaries. Potential cases are reviewed by team Chairs to determine if the criteria for review are met and if so the cases are added to the agenda for the next meeting. Prior to a meeting team member agencies are given

a list of the cases to be reviewed and are responsible for acquiring and bringing to the meeting all pertinent records.

Today, Louisville has created the Lethality Assessment Program “LAP” which focuses on relationship history, dynamics and lethality and it engages victims with social services in the community that can attend to the diverse needs of victims. The LAP provides victims at the scene of a police involved intimate partner violence incident with education about their level of risk for lethal and near lethal intimate partner violence if they remain in the abusive relationship. The LAP also provides information about and referrals to community resources which can provide assistance. The LAP involves a 2-step process. First, a police officer responding to the scene of a domestic violence incident utilizes a brief 11-item risk assessment to identify victims at high risk of homicide. Second, women that screen in as “high risk,” based on the Lethality Screen, are immediately put in telephone contact with a social service provider who provides safety planning and referral for services.

Lexington and Fayette County

The Lexington/Fayette County team also adopted a protocol and began reviewing cases in 1996. Team members included the following: the Coroner’s Office, Bluegrass Domestic Violence Program, Bluegrass Rape Crisis Center, the Department for Community Based Services, a District Court Judge, Domestic Violence Prevention Board, Commonwealth’s Attorney, County Attorney Victim Advocate, County Attorney, Fayette Public Schools, Fayette County Sheriff, Probation/Parole, Lexington-Fayette Urban County Government and other agency representatives with a legitimate interest in a case.

The team reviewed approximately 10 cases until review was suspended at or around 2002 to await an anticipated statewide plan. Data collection played a big part of the new state plan and the Lexington team wanted its data to be consistent. When it became clear that a statewide plan would not be announced, the Lexington team once again began reviewing cases in 2007. The team reviewed approximately 10 additional cases between 2007 and the Summit in 2011.

According to the guidelines in effect in 2011, the purpose of the Fayette County Domestic Violence Fatality/Near Fatality Review Team is to refine, improve and coordinate the community’s response to domestic violence crime in order to prevent future injuries and fatalities. Through case review the team identifies gaps in services; recognizes patterns that may indicate escalating violence and the threat of death; assesses the current responses of the criminal justice and social services systems to victims of domestic violence; supports cooperation and communication among agencies; and formulates findings and recommendations aimed at improving the community’s system of prevention and intervention services. Like the Louisville team, the purpose of this team is also not to fix blame but to analyze and refine systems response to the problem. This team, too, considers confidentiality a critical issue. All team members must sign a confidentiality agreement before each meeting.

The Fayette County team reviews fatality and near fatality cases including homicide or suicide of any family member or intimate partner that are domestic violence related and in which the

domestic violence occurred primarily in Fayette County. Any member of the team may request that a case be reviewed. Cases are not reviewed until the law enforcement agency has completed its investigation or, if criminal charges are placed, until the prosecution has been completed as far as the trial level. The team Chair with assistance from the Domestic Violence Prevention Board will designate a meeting time and location and notify members of the case(s) to be reviewed. Involved agencies and organizations will bring all records and information relevant to the cases(s) to the meeting.

In addition to reviewing cases involving domestic violence fatalities, Lexington-Fayette County also has a high risk domestic violence response or "Red Flag" team. The purpose of this team is to facilitate a coordinated and collaborative community effort to identify and address high risk domestic violence cases. The team meets every other week with the goal of streamlining communication among agencies and determining appropriate interventions that increase offender accountability and reduce the risk of harm to victims. Referrals are made through an on-line referral system located on the Commonwealth's Attorney's website. Once a referral is made, the team discusses the case at its next meeting and decides as a group whether or not it is appropriate for "Red Flag." One of the determining factors as to whether a case is classified as a "Red Flag" case is whether or not the team can identify action steps that can be taken to reduce risk. Team review does not relieve individual members of the responsibility to take action, as they always have, through their regular job responsibilities. Team approval is not required for members to do what they would otherwise normally do. However, as a team they can often piece together a more comprehensive plan for risk reduction than they could think of or implement individually.

METHODOLOGY

A STATE PLAN

In 2002 a statewide fatality review plan was envisioned. Ms. Carol Jordan, (then Executive Director of the Governor's Office of Child Abuse and Domestic Violence Services), Mr. Jim Grace (then a member of Ms. Jordan's staff), Ms. Teri Faragher (Executive Director of the Lexington Fayette County Domestic Violence Prevention Board), Dr. TK Logan (Professor, University of Kentucky) and Hon. Jerry Bowles (Judge, Jefferson Family Court) attended a national conference to learn about the various types of domestic violence fatality review initiatives taking place around the country so that they could better assist developing a statewide plan for Kentucky.

Thereafter, a state domestic violence fatality review council would be established with a two-fold purpose. First, the council would be available along with staff to assist in developing local teams, provide technical assistance, provide a link between teams and assist them in sharing expertise/serving as resources for each other, and develop model protocols and tools for use by local teams. Second, a state domestic violence fatality review team would be established. Local communities wishing to have a more extensive review (such as one involving interviews of family members) could invite the state team to review a particular case.

In 2010, the National Domestic Violence Review Initiative, funded by the Office on Violence Against Women and the United States Department of Justice and located at Northern Arizona University, published a state by state matrix of then-existing domestic violence fatality review teams. Based upon the information contained in that matrix and obtained through additional research by OAG staff, it was determined that in 2011, 14 states had statewide domestic violence fatality review teams.³ All except Kansas, New Hampshire and Utah were established by legislation. Through legislation or other means, 18 states authorize local or regional teams. The authorizing legislation in Michigan specifically permits a state team or local teams but a state team had not been created. Similar legislation allowing for either state or local teams in Alabama did not pass. Additionally, a similar process is used in that Connecticut called investigative reports. Finally, 18 states appeared to not have domestic violence fatality review teams at any level - local, regional or state.

OBJECTIVES OF FATALITY REVIEW

Domestic Violence Fatality Review typically has the objectives of preventing domestic violence fatalities in the future, preserving the safety of battered women and holding accountable both the perpetrators of domestic violence and the multiple agencies and organizations that come into contact with the parties.⁴

³ West Virginia, Delaware, Florida, New Mexico, Hawaii, Iowa, Kansas, Maine, Montana, Oklahoma, New Jersey, Utah, Vermont, and New Hampshire.

⁴ National Domestic Violence Fatality Review Initiative, http://www.ndvfri.org/?page_id=189 (Northern Arizona University, 2010).

WORK AND RESULTS OF THE SUMMIT COMMITTEES

After reviewing the history of domestic violence related services, legislation and initiatives, Kentucky's current statutory framework, the current status of domestic violence fatality review in Kentucky, and across the country and the sources of domestic violence fatality data currently available, Summit participants decided to continue their work through two committees: research and data collection and protocol development.

Research and Data Collection Committee

The Research and Data Collection Committee also met on several occasions at the Attorney General's east office in Frankfort. Soon after the committee began its work it found, what its members already suspected to be true, that Kentucky did not have adequate data or an adequate data collection system to provide a clear picture of the extent and nature of domestic violence fatalities in the Commonwealth. Believing that such data was critical to guiding the future work of the committee, the members set as their first priority the development of a data collection tool to collect information about the domestic violence related deaths from the prior calendar year, 2010. With assistance from many agencies and individuals, domestic violence related deaths from 2010 were identified; data was collected and ultimately analyzed by Dr. TK Logan. A copy of that report, prepared by Dr. TK Logan, is attached in the appendix.

Protocol Development Committee

The Protocol Development Committee met at the Attorney General's east office in Frankfort. Prior to the meeting, OAG staff identified communities that could potentially serve as pilot sites for the establishment of new fatality review teams. Bowling Green/Warren County was then selected. Technical assistance in setting up a team was provided by staff from the OAG's Office of Victim Advocacy. The Committee drafted model documents, based on the protocols in use in Louisville and Lexington, which have been made available to Bowling Green and other communities interested in starting domestic violence fatality review teams. Copies of those documents can be found in the appendix of this report. The committee also identified potential legislative changes that would assist in keeping victims safe and enhance the functioning of local teams.

LEGISLATIVE UPDATES

2012-2013

The information provided below summarizes many of the significant changes made in the areas of domestic violence, sexual assault, human trafficking, child abuse and victim rights by the 2012 and 2013 Kentucky General Assembly. Copies of the bills referenced below may be accessed through the Legislative Research Commission's website at www.lrc.state.ky.us.

2012

SB 58 - Fourth Degree Assault, Arrest - Amends KRS 431.005 to permit a peace officer to make an arrest or issue a citation for a violation of KRS 508.030, assault in the 4th degree, which is a misdemeanor, even when the officer did not view the commission of the offense if there is probable cause to make the arrest if the assault occurred in the emergency room of a hospital; amends KRS 431.005 to define emergency room; and amends KRS 431.015 mandating the use of a citation in lieu of arrest to exempt an arrest for 4th degree assault in a hospital emergency room.

HB 519 – Abused Child, Person in a Position of Authority or Special Trust - Amends KRS 600.020 to expand the definition of sexual abuse and sexual exploitation to include acts committed by persons in a position of authority or special trust, and amends the definition of an abused child to include persons in a position of authority or special trust and persons over 21 years of age who commit an act of sexual abuse, sexual exploitation, or an act of prostitution against a child less than 16 years of age; amends KRS 510.060 and 510.090 to change the age of the victims of those offenses from less than 16 to less than 18 when the offense is committed by a person in a position of authority or special trust; and amends KRS 530.020 to include aunt, uncle, step-grandparent, and step-grandchild within the proscribed incest relationships.

2013

SB 15 – Violent Offenders and Criminal Homicide - Amends KRS 439.3401 to provide that persons convicted of criminal homicide under KRS 507.040 and 507.050, where the offense involves the killing of a peace officer or firefighter while in the line of duty shall be classified as a violent offender and sets new parole eligibility thresholds at 85% and 50%.

SB 78 - Crime Victims Compensation Board, Expungement, Corrections- Amends KRS 216B.400 to require that a medical exam of a crime victim has to occur within twelve months of the medical provider's application to receive reimbursement; amends KRS 346.040 to permit the Crime Victims Compensation Board to negotiate a binding settlement for recoverable expenses with the provider after a claim has been filed; creates a new section of KRS Chapter 346 to provide that debt collection actions against crime victims, where the debt incurred is related to a recoverable claim through the board, shall cease pending action by the board and establishes procedures; amends KRS 346.130 to permit the use of court records to establish the occurrence and reporting of criminal conduct and permits an award for loss of earnings or support if due to the crime and provides that the award shall be equal to net earnings at the time of the crime; amends KRS 346.140 to add donations made on behalf of a victim to the listing of offsets to be made against awards; amends KRS 532.162 to provide that if a court

orders a defendant to pay restitution for criminal conduct, that reimbursement may be directed to the Crime Victims Compensation Board as appropriate; repeals KRS 346.190, relating to reciprocal agreements with other states; amends KRS 431.078 to insert provisions clarifying the effect of traffic tickets on expungement requests and requires that a certificate of eligibility completed by the State Police and the Administrative Office of the Courts be submitted with all expungement petitions; amends KRS 6.949 to modify the contents of corrections impact statements; amends KRS 27A.097 to make a technical correction; amends KRS 197.045 to clarify the types of programs that qualify for institutional credits and applies specified credits retroactively; amends KRS 439.3406 to clarify that mandatory reentry supervision is to be applied six months prior to the projected completion date of the inmate's sentence; amends KRS 441.045 to authorize a correctional facility to apply for Medicaid on an inmate's behalf; and amends KRS 441.430 and 441.440 to clarify language relating to construction of jails.

HB3 – Human Trafficking Victims Rights Act – Creates a new section of KRS Chapter 620 to require the Cabinet for Health and Family Services to investigate reports alleging a child is a victim of human trafficking and provide or ensure the provision of treatment, housing and services and proceed in the case in accordance with statutes governing cases involving dependency, neglect and abuse; amends KRS 620.030 to require any person who knows or has reasonable cause to believe that a child is a victim of human trafficking to make a report to the Kentucky State Police or local law enforcement, the Cabinet or the Commonwealth's or county attorney; amends KRS 620.040 to include advocates for victims of human trafficking as members of multidisciplinary teams and requires the teams to review child human trafficking cases involving commercial sexual activity; creates a new section of KRS Chapter 630 to provide that if reasonable cause exists to believe a child is a victim of human trafficking the child shall not be charged with or adjudicated guilty of a status offense related to conduct arising from the human trafficking of the child unless it is determined at a later time that the child was not a victim of human trafficking at the time of the offense; creates a new section of Chapter 529 which creates a human trafficking victims fund; creates a new section of KRS Chapter 529 to provide for forfeiture of property used in connection with or acquired as a result of a violation of KRS 529.100 or 529.110 and provides for the distribution of the funds; amends KRS 15.334, 15.718 and 421.570 to provide for mandatory training for law enforcement officer, prosecutors and victim advocates on specified human trafficking related topics; creates a new section of KRS Chapter 16 to provide that the Department of Kentucky State Police designate a unit to receive and investigate complaints of human trafficking; amends KRS 421.500 to include victims of human trafficking within the definition of "victim" for purposes of the Crime Victims Bill of Rights; amends KRS 421.350 to include proceedings under KRS 529.100 and 529.110 in the list of those for which closed circuit or recorded testimony of the child may be used if the requisite conditions are otherwise met; creates a new section of KRS Chapter 336 that provides that the

cabinet shall report, within 24 hours, all incidents of human trafficking about which the cabinet knows or has reasonable cause to believe to a local law enforcement agency or the Kentucky State Police and the appropriate Commonwealth's attorney or county attorney.

HB 39 – Child Pornography - Amends KRS 17.546 to prohibit a registrant from intentionally photographing, filming or videoing a minor without written consent of the minor's parent, legal custodian or guardian unless the registrant is the parent, legal custodian or guardian; amends KRS 500.092 to permit all real and personal property in this state that is used in connection with or acquired as a result of a violation or attempted violation of KRS 531.310 or 531.320 to be subject to forfeiture; permits the commissioner of the Department of Kentucky State Police to issue and cause to be served a subpoena when specified offenses within KRS Chapters 510, 530 and 531 are being investigated and there is reasonable cause to believe that an internet service account has been used in the exploitation or attempted exploitation of children; amends KRS 510.155 to specify when the offense is complete; and amends KRS 531.355 to criminalize the intentional viewing of child pornography where the viewing is deliberate, purposeful, and voluntary and not accidental or inadvertent.

HB 222 – Crime Victim Address Protection Program - Creates new sections in KRS Chapter 14 to establish a crime victim address protection program for victims of domestic violence and abuse, stalking, and felony sexual offenses; to allow crime victims to use an address provided by the Secretary of State in lieu of the person's actual physical address; and to allow program participants to vote by mail-in absentee ballot; amends KRS 117.085 to conform.

HB 366 – Crime Victim Address Protection Program - Creates a new section of KRS Chapter 14 to permit the Secretary of State to expand the address confidentiality program created by HB 222.

HB 290 – Child Fatalities and Near Fatalities - Creates a new section of KRS 620 to establish an external child fatality and near fatality review panel; establishes its membership, duties, and responsibilities; and amends KRS 620.050 to allow records to be provided to the panel.

LIMITATIONS AND RECOMMENDATIONS

The work in compiling this report was completed by individuals volunteering countless hours in assuring that the data presented was precise and accurate. As we look into the future, funding is imperative. Without it, our ability to work collaboratively is limited. No additional state funding was made available for this report.

The Office of Victims Advocacy of the Office of Attorney General has, however, submitted an application for Federal Grant Funding as we move forward with this endeavor.

CREATING A FATALITY REVIEW TEAM IN YOUR COUNTY:

A GUIDE TO DEVELOPMENT OF MODEL POLICIES AND PROCEDURES

“KEY DECISIONS TO GETTING STARTED”

A Guide to starting a domestic violence fatality review team in your community.

I. Introduction.

Domestic Violence Fatality Review refers to the “deliberative process for identification of deaths, both homicide and suicide, caused by domestic violence, for examination of the systemic interventions into known incidents of domestic violence occurring in the family of the deceased prior to the death, for consideration of altered systemic response to avert future domestic violence deaths, or for development of recommendations for coordinated community prevention and intervention initiatives to eradicate domestic violence.” The process can be formal or informal, very detailed or relatively superficial gathering only basic demographic information about the victim and perpetrator¹. In Kentucky, KRS 403.705 permits the establishment in any jurisdiction or group of counties local domestic violence coordinating councils. KRS 403.705(4) specifically provides that “local domestic violence coordinating councils may, if authorized by the local coroner or a medical examiner, create a domestic violence fatality review team. . . .”

Local domestic violence fatality review teams are specifically authorized to analyze information regarding local domestic violence fatalities to identify trends, patterns, and risk factors; evaluate the effectiveness of local prevention and intervention strategies; recommend changes in Kentucky statutes, administrative regulations, policies, budgets and treatment and service standards that may facilitate the prevention of domestic violence fatalities; establish a protocol for investigation of domestic violence fatalities; and establish operating rules and procedures it deems necessary to carry out its purposes. KRS 403.750(6).

II. Getting Started.

Several key decisions must be made when starting a local team. These key decisions and possible options are set forth below.

A. *Do We Need A Formal Protocol or By-laws?*

Before beginning case review, each team should develop and have each team member or an agency representative sign a protocol on how fatality review will be conducted by the county team. Answering the questions below will assist you

in drafting your protocol and help insure that all key provisions are covered. Additionally, the Office of the Attorney General's Office of Victims Advocacy can provide samples for your use.

B. What is the Purpose and Objectives of Our Case Review?

The primary purpose of local domestic violence fatality review teams in Kentucky is "to prevent future deaths and injuries related to domestic violence." KRS 403.705(5). Most teams throughout the country share a similar purpose and the underlying objectives of preventing domestic violence fatalities in the future, preserving the safety of battered women and their children and holding accountable both the perpetrators of domestic violence and the multiple agencies and organizations that come into contact with the parties. The purpose of fatality review is typically not to review the investigation, prosecution and/or ultimate outcome of the case.

C. What is Our Philosophy?

Many teams have found it useful to adopt a "no blame, no shame" philosophy. Philosophies that point fingers and seek to impose blame are counterproductive and might encourage the covering up of information. It is the batterer or his violent behavior that has caused the death or serious injuries in question. This philosophy, however, does not remove the need for agency accountability. It recognizes that the case review process helps the team make informed decisions for systems improvement and agency coordination that will save lives.

D. Who Should be Invited to Participate on Our Team?

Usually fatality review teams are inclusive rather than exclusive. Anyone remotely involved with or affected by a domestic violence fatality might serve on a team. Typical, minimum membership of a local team might include: the coroner, Commonwealth's and/or County Attorney, law enforcement, judges/court personnel, domestic violence program staff, DCBS adult protection staff, and victim advocates. Additional team members might include: medical, public health, mental health, animal control, Legal Aid, DCBS/child protection staff, probation and parole, batterer intervention program, housing authorities, substance abuse, faith community, researcher, immigrant service providers, and citizens at large. Some members, such as animal control, may choose to participate only when the agency is involved or should have been involved with a particular case.

E. What Types of Cases Should We Review?

Teams across the country review a wide variety of cases. Case review can include: death or near death of the intended domestic violence victim, domestic violence related suicide, death or near death of an innocent bystander, death or near death of a third party who intervened on behalf of the intended victim or secondary victims who were killed to hurt the victim. Teams also sometimes review all deaths of women between certain ages, high-profile cases deemed significant by the community and cases involving familicide.

Case load and confidentiality considerations are two factors that may impact a team's decision on this issue. For example, currently Kentucky law does not protect the confidentiality of the review of non-fatality cases. As a result the Louisville team, which reviews open cases, is not currently reviewing these cases. The Lexington team, however, reviews only closed cases, so it has not changed its practice of reviewing these cases.

F. When Should a Case be Reviewed?

Most teams review only closed cases. Typically a case is considered closed upon conviction of the perpetrator but some wait until most or all appeals have been exhausted. The Lexington team reviews only closed cases and finds that because discovery is no longer an issue it is easier to get the key players to participate. The Louisville team, however, reviews open cases, and has found that it has allowed them to identify needed system improvements sooner and to implement them in a timelier manner.

G. Who can request review of a particular case?

For many teams, the Chair or Co-Chair, with assistance from team staff, identify cases for review. Other teams allow any member of the team to request review of a particular case. One state even allows and encourages citizens to request review. Regardless of who is allowed to recommend cases for review, cases should be checked by staff or the team Chair or Co-Chairs to insure that they meet all criteria for review before being placed on the meeting agenda for review.

H. What About Confidentiality?ⁱⁱ

Confidentiality considerations generally fall into two categories: first, information relating to the lives and deaths of the persons whose cases are being reviewed and second, information regarding the fatality review process itself such as deliberations, findings, work products and reports.

It is not unusual for team members to become aware of private information about the victim during the course of its review. It is critical that team members respect the privacy of the person whose life and death it is studying. At the same time the team must balance the public's "right to know." Teams should provide to the community information about what the community should be doing to intervene in and prevent domestic violence and domestic violence homicides.

Team members should also be made aware of the extent to which existing confidentiality laws protect the proceedings, discussions and records of the team from disclosure. Existing laws provide that proceedings, records, opinions, and deliberations of the domestic violence fatality review team shall be privileged and shall not be subject to discovery, subpoena, or introduction into evidence in any civil action in any manner that would directly or indirectly identify specific person or cases reviewed.

In order to best maintain the confidentiality necessary for a successful team, team members should be required to sign a confidentiality form at the beginning of each meeting which bars disclosure of team matters and information outside of team members or the team meeting.

I. How Does a Fatality Review Team Operate?

Teams operate in a variety of ways depending on the resources available, members participating, local preferences and whether or not there is controlling or guiding legal or legislative direction. The actual team review involves those agency players who bring information to the table in order to discuss domestic violence related deaths or near deaths.

1. Selecting a Chair or Co-Chairs. Usually one or two members of the team assume leadership or are selected by the membership to lead the team, coordinate meetings and handle the other related duties. These individuals are usually actively involved in working on domestic violence cases and are in professional positions that allow them to encourage the active participation and orchestrate the activities of a wide range of professionals. Many teams prefer rotating leadership in order to avoid burnout and inject new ideas. For other teams certain professionals are best positioned by their jobs, such as the coroner or prosecutor, to serve as on-going Chair of the team. This person is typically one who has the ability to bring the key players to the team and lend immediate credibility to the work of the team.
2. Practical Steps in Reviewing a Case.ⁱⁱⁱ (Note: Review may take more than one meeting).

- Select cases for review per team protocol.
- Send out meeting notices.
- Have all members sign the confidentiality agreement at the start of each meeting.
- Remind members of the team philosophy and the need to maintain confidentiality prior to beginning case review.
- Discuss agency involvement and review documents.
- Create a timeline of events leading up to the death, identify possible red flags, determine agency involvement and degree of collaboration and coordination, and make recommendations for systems improvement.
- Summarize the review.
- Distribute review findings and implement recommendations per team protocol.

J. Is There A Role For Family Members and Friends?

Working with friends and family members of homicide victims is difficult. Some may approach team members and want to share information about the case. Others may not want to talk at all. Friends and relatives of the perpetrator may also want to participate and may have information that would be valuable to the review of the case. Therefore, it is critical that the issue of interviewing victim or perpetrator contacts be addressed in the team protocol prior to beginning case review.

Some teams choose not to interview these contacts at all while others only interview such individuals when they approach the team with a willingness to provide information. Other teams rely on a team member who is a trained counselor to gather information from these individuals. In situations where friends or family members of the victim or perpetrator are interviewed or asked to provide information it is important that the person be fully informed about the limits confidentiality laws place on the team regarding what they can share.

K. What Documents Should the Team Review?

Teams should review any documents available to them that might assist them in better understanding the case being reviewed. Confidentiality laws, however, may prevent team access to some documents that would otherwise be helpful to the team review. Useful information can often be gained from the following types of documents:^{iv}

- Police department logs
- Newspaper reports
- Crime scene investigations
- Follow-up investigative reports
- Details of prior protective orders including service and notice of service.
- Affidavits requesting issuance of a protective order
- Civil court data such as divorce, termination of parental rights, child custody battles, or child visitation
- Criminal histories of the perpetrator or victim
- Summaries of psychological evaluations or reports
- Medical examiner/autopsy reports
- Medical information from physician, EMS or hospital
- Workplace information such as harassment, alerts, etc.
- Domestic violence or sexual assault program information
- School information such as reports of child abuse in the home
- DCBS information
- Statements from friends, neighbors, witnesses, etc. which may be found in other records such as police files, court transcripts, etc.
- Presentence Investigation Report
- Probation, Parole or other release information including notice to victims
- Information on weapons purchase, confiscation, background checks, etc.
- Mental health information
- Drug and alcohol treatment information
- Counseling/batterer intervention treatment information

L. Are We Required to Keep Data or Issue Reports?

There is nothing in existing law that requires a team to keep specific data or issue a report. However, the information gained from your case review will not only be helpful to you at the local level but will also be of assistance to the domestic violence fatality review work that is being done at the state level. We only ask that if you choose to receive organizational and/or staffing support from the Office of the Attorney General and/or the State DVFR Advisory Committee that you use the data collection form that we provide. This will enable us to assist you in completing any reports that you might want for use locally and will also allow us to include your information in our annual statewide report.

Most teams, however, do prefer to issue an annual report. These reports give coherence to the work of the team. “Team reports often make formal findings and offer recommendations for action such as public awareness and prevention campaigns, and can focus attention on needed system reforms or on particular

topics such as suicide, teens, marginalized women, or firearms.”^v Data and other aggregate information are also usually gathered. This information, gathered from the review of multiple cases by a single team or the combined information from several teams can support changes in policy and resource allocation, legislative reform and can also raise awareness.

III. Conclusion

For more information about domestic violence fatality review or for assistance in starting a team in your county contact the Office of the Attorney General, Office of Victims Advocacy (OVA) at 502-696-5312. A member of the OVA staff or the state Domestic Violence Fatality Review Advisory Committee will be available to answer your questions and otherwise assist you as needed.

ⁱ National Domestic Violence Fatality Review Initiative, OVW, USDOJ (Northern Arizona University, 2011); Barbara Hart.

ⁱⁱ Thompson, Robin. Fatality Review Bulletin, *Confidentiality and Fatality Review* (Vol. 3, Issue 3, Winter 2002).

ⁱⁱⁱ Bowman, Alana. 1997. “Establishing Domestic Violence Review Teams.” Domestic Violence Report, August/September 1997, pp. 83, 93-94.

^{iv} National Domestic Violence Fatality Review Initiative, OVW, USDOJ (Northern Arizona University, 2011)

^v Id.

APPENDIX

MODEL PROTOCOL FOR DOMESTIC VIOLENCE FATALITY REVIEW TEAM

PURPOSE and PHILOSOPHY

The purpose of the _____ County Domestic Violence Fatality Review Team (DVFRT) is to prevent future deaths and injuries related to domestic violence. To accomplish this purpose the DVFRT seeks to identify areas and means by which to increase and enhance coordinated agency and community responses to domestic violence through a systems-review approach by conducting multidisciplinary and multi-agency examinations of domestic violence fatalities. Through analysis and review of domestic violence cases resulting in fatalities, the DVFRT will:

- Improve interagency communication and coordination;
- Recognize patterns that may indicate escalating violence and the threat of death;
- Collect and produce data on domestic violence fatalities in _____ County;
- Educate the public on the dynamics of domestic violence and related fatalities;
- Identify gaps and unmet needs in the current domestic violence response systems; and
- Recommend and assist in implementing system improvements.

The purpose of the DVFRT is not to affix blame or to challenge difficult decisions made by involved agencies, but rather, through constructive self-criticism to analyze and refine systems response to this serious problem. The team will work to balance its “no blame, no shame” philosophy with the need for agency accountability.

COMPONENTS OF THE TEAM

Leadership

The Commonwealth’s Attorney will serve as chairperson of the DVFRT. He/she may designate another representative to serve as chair in his/her absence or at his/her discretion.

Staff

The _____ (inset agency/office) will provide support staff.

Membership

- Members:
Members of the team will include the Commonwealth’s Attorney, the County Attorney, the Coroner, the _____ County Sheriff, the _____ Police Department, Domestic Violence Program, Sexual Assault Program, Judges and/or other court system representatives, Department for Community Based Services and other agencies determined by these agencies to be critical to accomplishing the mission of the DVFRT.

- Roles and Responsibilities:

Providing Information and Participation in Review Process

Members will be responsible for the provision of information from their agencies and organizations (consistent with agency/organization confidentiality policies) related to the cases under review. They must agree to comply with confidentiality measures due to the sensitive nature of the information provided. Members will also be expected to participate in the coordination and review of provided information as well as to objectively evaluate the data reviewed.

Maintaining Confidentiality

A family who has lost a member deserves privacy. All information that relates to the identity of the family will remain confidential to team members and to those professionals involved with the treatment of the victim and/or perpetrator. General statistical and educational information can be released to the public provided that the identification of the victim, perpetrator, and family are withheld. The Chair of the team will be informed whenever a team member is contacted by a member of the media.

Cooperating with Investigations

Any evidence that the DVFRT might discover that suggests undocumented abuse or any other criminal activity will be promptly turned over to the appropriate law enforcement agency. The DVFRT recognizes that if a case is still under investigation by any agency, it might not be appropriate for that agency to share information with the team.

Making Findings and Recommendations

Active participation of all team members in the case review process is important to accomplishing the mission of the team. System improvements can best be accomplished through review and implementation of the findings and recommendations of the team made after input from all members. Formal recommendations shall be voted on and approved by the majority of members present at the meeting and disseminated to appropriate agencies or organizations for review and potential implementation.

Conflict of Interest

It is the responsibility of each team member to note any potential conflict of interest prior to the start of the case review.

MEETINGS

Meetings will be conducted by the Chair. The team will convene initially to approve a protocol for the work of the team. The protocol will, at a minimum, clarify member roles and responsibilities, outline the review process and decide upon criteria for cases to be reviewed.

Subsequent meetings will be held within 10 days of the Chair identifying a case as meeting criteria for review on a date and time and at a location determined by the Chair. Written notices of meetings will be provided to team members by staff. Follow-up meetings will be scheduled as needed as determined by the Chair.

An annual meeting will be held near the close of each calendar year to review the effectiveness of the team protocol and the work and findings of the team during the preceding year.

CASE SELECTION and REVIEW PROCESS

Criteria for Inclusion:

- Fatality resulting from domestic violence.
- Open case
- Deceased:
 - Adults, 18 and older.
 - Children, when injured as a means to control, coerce, or hurt the primary adult domestic violence victim.
- Location:
 - Domestic violence primarily occurred in _____ County
 - Residence in _____ County

Case identification and selection:

Cases may be identified for review by agency request, member request or media reports. Once identified, the Chair or Co-chair will determine if review criteria are met and if so, a meeting will be scheduled within 10 days.

Questions the team will seek to answer:

1. Which agencies/organizations had contact with the victim and perpetrator in the case?
2. What services were provided to the victim?
3. Were all current policies and procedures followed in the handling of criminal matters and/or civil matters involving the case?
4. Did any criminal justice or civil system agency/organization have contact with the victim or perpetrator related to a domestic violence protective order?

5. What changes could be made to improve the response of involved agencies/organizations/individuals?
6. Was there sufficient sharing of information among all agencies and organizations involved in the case?
7. Is sufficient local data collected to evaluate the effectiveness of the current intervention efforts in domestic violence cases?
8. What changes in data collection procedures are necessary to obtain the needed information?

The Review Process:

- Team Chair will select cases for review per team protocol.
- Team staff will send out meeting notices designating date, time and location of the meeting.
- Team members will gather agency/organization records and information regarding all contacts and actions relevant to the case and will take them to the meeting.
- All members sign the confidentiality agreement at the start of each meeting.
- Team Chair will remind all members of the team philosophy and the need to maintain confidentiality prior to beginning case review.
- Team Chair will lead a discussion of the case history, agency involvement and intervention and review of documents identifying strengths and weaknesses in the response network. Creation of a timeline of events leading up to the death may help the team identify possible red flags; determine agency involvement and degree of collaboration and coordination.
- Summarize the review and make findings and recommendations for improvement as appropriate.
- Distribute review findings and implement recommendations per team protocol.

DATA COLLECTION and ANNUAL REPORT

Team members will determine the specific data to be collected. Data will be collected and a report prepared annually. At a minimum, the report should include the number and types of cases reviewed, any findings or recommendations and the data collected.

MODEL SIGN-IN / CONFIDENTIALITY STATEMENT

The purpose of the _____ County domestic violence fatality review team (DVFRT) is to prevent future deaths and injuries related to domestic violence. To accomplish this purpose the DVFRT seeks to identify areas and means by which to increase and enhance coordinated agency and community responses to domestic violence through a systems-review approach by conducting multidisciplinary and multi-agency examinations of domestic violence fatalities. In order to assure a coordinated response that fully addresses all systemic concerns surrounding domestic violence fatality cases, the DVFRT must have access to all existing records on each case (consistent with each agency or organization confidentiality policy). This includes, among others, social services reports, court documents, police records, autopsy reports, mental health records, hospital or medical records and any other information that may have a bearing on the case under review. The DVFRT has adopted a “no blame, no shame” philosophy which respects the input of all members and provides for a safe environment in which the ultimate goal of improving the community response to domestic violence is held as the highest priority. The information shared of all cases and member input during review meeting is protected by statute. All members and guests of the DVFRT must respect the privacy and confidentiality of this process for its guaranteed success.

With this purpose in mind, the undersigned, agree that all information secured in this review, written or verbal, will remain confidential.

NAME	SIGNATURE	AGENCY REPRESENTED / POSITION ON COMMITTEE	E-MAIL ADDRESS (if not previously provided)

**Domestic Violence Fatality
— Special Report —**

KENTUCKY 2010 HOMICIDES

**Prepared for the Statewide
Fatality Review Committee**

October 2014

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TABLE OF CONTENTS

EXECUTIVE SUMMARY 4

INTRODUCTION..... 6

STATEWIDE CASE IDENTIFICATION 7

STATEWIDE CASE CHARACTERISTICS 8

SUPPLEMENTARY HOMICIDE REPORT (SHR) CASE IDENTIFICATION..... 20

SUPPLEMENTARY HOMICIDE REPORT (SHR) CASE CHARACTERISTICS..... 21

SHR CASE TREND ANALYSIS 24

CONCLUSION AND LIMITATIONS 25

REFERENCES 29

APPENDIX A: STATEWIDE DOMESTIC VIOLENCE FATALITY INFORMATION SURVEY 30

EXECUTIVE SUMMARY

Close to 1 in 3 adult women and 5% of adult men in the U.S. have experienced rape, physical violence, and/or stalking, which caused fear or concern for safety, by an intimate partner. Of the known intimate partner homicides in 2008 in the U.S., 45% of female homicide victims and 4.9% of male homicide victims were murdered by an intimate partner. Despite the high rates and the potential lethal outcomes of intimate partner violence, Kentucky has no formal statewide surveillance to track intimate partner violence-related homicides and no formal statewide procedure to review intimate partner-related homicide cases. As an initial step, this report examines intimate partner homicide cases in Kentucky for 2010.

Specifically, this report: (1) explores the identification and characteristics of 35 intimate partner-related homicide cases from 2010 (Statewide Cases); (2) describes the identification and characteristics of 32 intimate partner-related homicide cases in Kentucky

from 2010 reported in the FBI's Supplementary Homicide Report data (SHR Cases); and (3) examines the intimate partner-related homicides in Kentucky from 2006 to 2011 reported in the Supplementary Homicide Report data (SHR Case Trend Analysis).

Despite the high rates and the potential lethal outcomes of intimate partner violence, Kentucky has no formal statewide surveillance to track intimate partner violence-related homicides and no formal statewide procedure to review intimate partner-related homicide cases.

A total of 35 intimate partner-related homicide cases (Statewide Cases) and 40 deaths were identified through two primary methods: (1) the Office of the Chief Medical Examiner; and (2) media articles collected by the Kentucky Domestic Violence Association. Case and victim specific characteristics were collected with a short survey, which was completed by Commonwealth's Attorneys and law enforcement offices in the counties where the deaths occurred. In addition, information about cases was

collected from the Office of the Chief Medical Examiner, Kentucky State Police, and media articles that were collected for every case identified.

For the 35 Statewide Cases, the majority of victims were

female and the majority of offenders were male. The vast majority of cases were single-victim homicides (94%) and nearly 40% were homicide-suicides. All of the homicide-suicide cases were male offender perpetrated.

A firearm was used to kill most frequently regardless of offender gender. However, of those that did not use a gun to kill their victim, close to half of female offenders stabbed their victim while male offenders stabbed, strangled, or beat their victims to death.

Overall, 2 in 3 victims and offenders were married or living together at the time of the homicide and the homicide occurred most frequently at the couple's shared residence (45.7%). Almost 2 out of 5 victims had minor children in common with the offender and no victims were pregnant at the time of the homicide. Further, 1 in 4 cases had some form of domestic violence-related civil and/or criminal justice activity (i.e., had an active Domestic Violence Order, a request for an Emergency Protective Order, an active No Contact court order, or a domestic violence-related call to police) within the year prior to the homicide. Also, 1 in 9 cases had some domestic violence-related civil and/or criminal justice activity within 30 days of the homicide.

Male perpetrated violence and abuse were exclusively mentioned in media articles for almost half of male offender cases, and just over half of female offender cases.

However, female perpetrated partner abuse and violence was not mentioned in any case. Media articles in two female perpetrator cases mentioned mutual violence between the offender and victim.

The results of the analysis of SHR Cases were consistent with the Statewide Case characteristics. Specifically, the majority of victims were female, the majority of offenders were male, and firearms were used to kill the victim regardless of offender gender in the majority of the cases.

The SHR case trend analysis of intimate partner-related homicides in Kentucky suggests that the number of intimate partner homicide cases have remained relatively stable over time rather than declining.

This report also highlights several significant limitations in identifying cases and collecting case characteristics for domestic violence-related

fatalities in Kentucky. These limitations include significant likelihood of under-identifying intimate partner-related homicide cases, concern about the amount of missing and unreliable information, and limited information about case characteristics leaving more questions than answers when trying to understand key risk factors.

In conclusion, partner violence-related homicides are preventable, yet there has not been a decline in the overall number of deaths over time in Kentucky. There were significant limitations in identifying intimate partner-related homicides in Kentucky and in understanding key case characteristics. A systematic and statewide surveillance system is needed to understand the scope of the problem and to follow trends over time. Also, a systematic process such as a formal fatality review to assess the nature and context of the problem/contextual factors is needed to help protect high-risk victims of intimate partner violence and their children.

INTRODUCTION

Close to 1 in 3 U.S. women and about 5% of U.S. men 18 years or older reported rape, physical violence and/or stalking by an intimate or ex-intimate partner (Black et al., 2011). Partner violence, threats of harm, and control are associated with intimate partner-related homicide (Campbell et al., 2003). Of homicide cases between 1980 and 2008 with a known victim-offender relationship², 16.3% of victims were murdered by an intimate partner (Bureau of Justice Statistics, 2011). Specifically, of the known intimate partner homicides in 2008, 45% of female homicide victims and 4.9% of male homicide victims were murdered by an intimate partner (Bureau of Justice Statistics, 2011).

Despite the high rates and potential lethal outcomes of intimate partner violence, Kentucky has no formal statewide surveillance system to track intimate partner violence-related homicides and no statewide formal procedure to review intimate partner-related homicide cases. A systematic and statewide surveillance system is needed to understand the scope of the problem and to follow trends over time. Also, a statewide procedure to assess the nature and context of the problem is needed to help protect high-risk victims of intimate partner violence and their children.

Close to 1 in 3 U.S. women and about 5% of men 18 years or older reported rape, physical violence and/or stalking by an (ex) intimate partner.

As an interim step, this report: (1) describes the identification and characteristics of 35 intimate partner-related homicide cases from 2010 (Statewide Cases); (2) describes the characteristics of 32 intimate partner-related homicide cases identified in Kentucky from 2010 reported in the FBI's Supplementary Homicide Report (SHR Cases); and (3) examines the intimate partner-related homicides in Kentucky from 2006 to 2011 reported in the Supplementary Homicide Report data (SHR Case Trend Analysis).

² Only 63.1% of all murders in the Uniform Crime Report Supplemental Homicide Report Data had known victim-offender relationships.

STATEWIDE CASE IDENTIFICATION

Intimate partner-related homicide cases that occurred in the state of Kentucky in 2010 were identified from two primary sources: (1) the Kentucky Office of the Chief Medical Examiner; and (2) media articles collected by the Kentucky Domestic Violence Association.

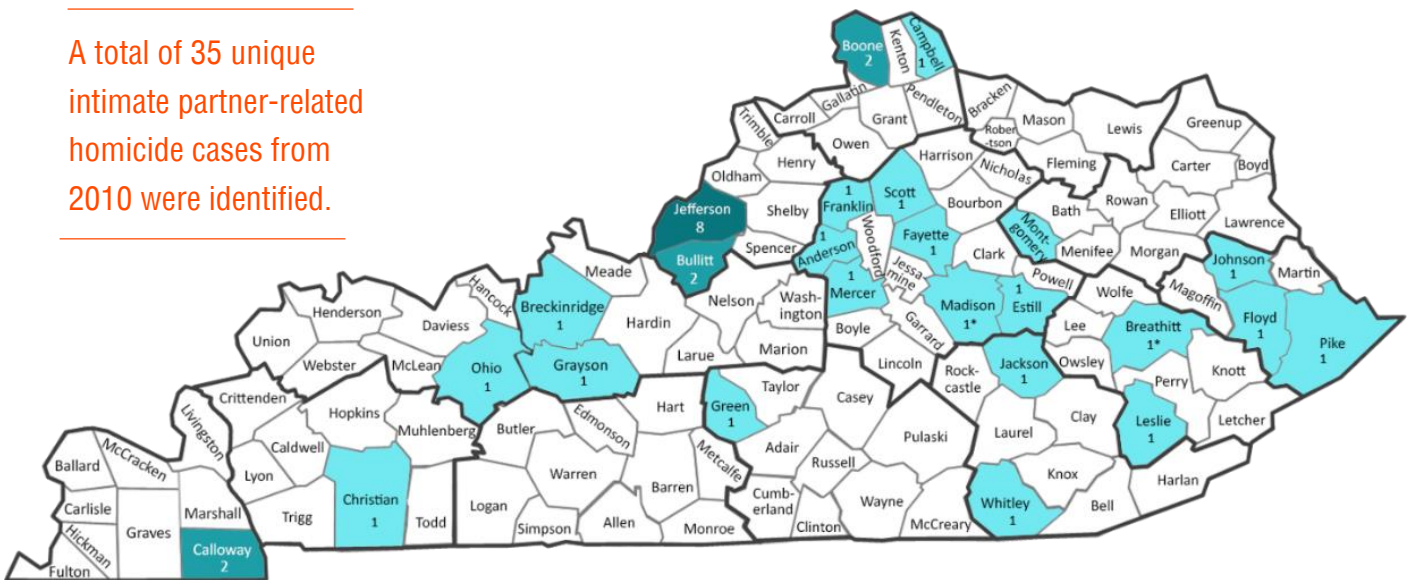
The Office of the Chief Medical Examiner's list originally included 42 victim names with the final list including 34 victim names. One name was removed because no information about the death was found. Seven names were removed because the cases were not intimate-partner related.³

The list of names generated from media articles originally included 18 names with the final list including 6 names not originally identified by the Office of the Chief Medical Examiner. Of the 18 names identified through the media, 12 overlapped with the Office of the Chief Medical Examiner's list.

Overall, there were 40 victims identified from the two methods above from 35 unique cases. Two of those cases involved multiple-victim homicides. These 35 intimate partner-related homicide cases from 2010 were located in 25 different counties as displayed in Figure 1.

Figure 1. Location of 2010 intimate partner homicide cases in Kentucky (n = 35)

A total of 35 unique intimate partner-related homicide cases from 2010 were identified.



*Multiple-victim homicides

³ In one case the offender's ex-girlfriend was present but not harmed at the time of the homicide.

STATEWIDE CASE CHARACTERISTICS

Method

Case Characteristics. There were 40 deaths and 35 unique cases identified from the Office of the Chief Medical Examiner and from the media articles. Two cases involved multiple-victim homicides. In one case, the offender's girlfriend and mother were shot and killed. In the other case the offender's wife and step-daughter were shot and killed in addition to a neighbor who was the step-daughter's boyfriend at the time and two other female neighbors. Because no information was available about the three neighbors, information on characteristics of the 37 homicide victims was collected.

A short survey was developed that included information about: (1) victim and offender demographics; (2) case characteristics; (3) victim and offender history; and (4) offender outcomes (see Appendix A). The survey was sent to the local Commonwealth's Attorneys and law enforcement offices in the counties where the homicides occurred by staff at the Kentucky Office of the Attorney General.

Surveys were requested for 37 homicide victims; however, only 30 surveys were completed. Further, few of the 30 surveys were entirely completed. Missing data were supplemented from three additional sources: the Office of the Chief Medical Examiner, media articles, and Kentucky State Police. Each of those additional sources of information had limitations in how much information was available. Media articles were collected for every case identified (n = 35) but were only used to supplement survey information as a last resort. Kentucky State Police also provided additional information on protective order history and Conceal Carry License history.

Six dead in shooting argument about how wife cooked eggs. Offender killed his wife, her daughter, and three neighbors before killing himself.

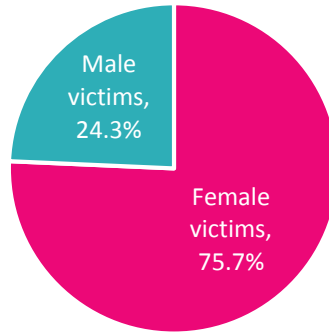
- **Media articles⁴**

⁴ Associated Press (2010, September 12). Man shot five because of way wife cooked his eggs. *The Guardian*. Retrieved from: <http://www.theguardian.com/world/2010/sep/12/man-shot-wife-cooked-eggs>

Victim and Offender Demographic Information

The majority of the victims were female (75.7%) and about one quarter (24.3%) of victims were male (Figure 2).

Figure 2. Proportion of female versus male victims (n = 37)



As Table 1 shows, victims were predominately white (86.5%), with a smaller proportion being black (10.8%) and Asian (2.7%). The average age of the victims was about 41 years-old ranging from 21 to 84 years-old.

Table 1. Victim demographic information

The majority of victims were female and the majority of offenders were male.

Victim Characteristics	
Race of Victim	N = 37
White	86.5%
Black	10.8%
Asian	2.7%
Average Age of Victim	N = 37
	41.2

The majority of offenders were male (74.3%) and about a quarter (25.7%) were female (Figure 3).

Figure 3. Proportion of male versus female offenders (n = 35)

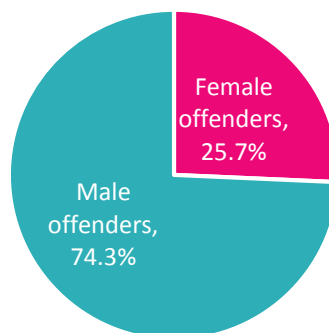


Table 2 shows the majority of offenders were white (85.7%) with a smaller proportion being black (14.3%). The average age of the offenders was 45 years-old ranging from 25 to 92 years old.

Table 2. Offender demographic information

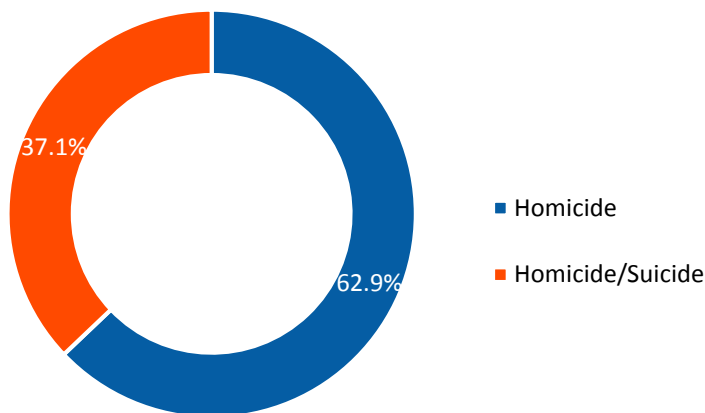
Offender Characteristics	
Gender of Offender	N = 35
Male	74.3%
Female	25.7%
Race of Offender	N = 35
White	85.7%
Black	14.3%
Average Age of Offender	N = 35
	45.3

Case Characteristics

Case Type. The vast majority of cases involved single-victim homicides (94.3%) as only two cases involved multiple-victims. Overall, 37.1% of the 35 cases were classified as homicide-suicides and 62.9% were classified as homicides (Figure 4). Only male offenders killed themselves after murdering their partner.

Almost 2 in 5 cases were homicide-suicides. Only male offenders killed themselves after murdering their partner.

Figure 4. Type of homicide (n = 35)¹



¹Media reports were used for 7 cases

The victim opened the store shortly after six in the morning and was taking care of customers when her husband came in. There were three other customers who were in the store, and he pulled a gun and made them leave. Then he killed her and took his own life.

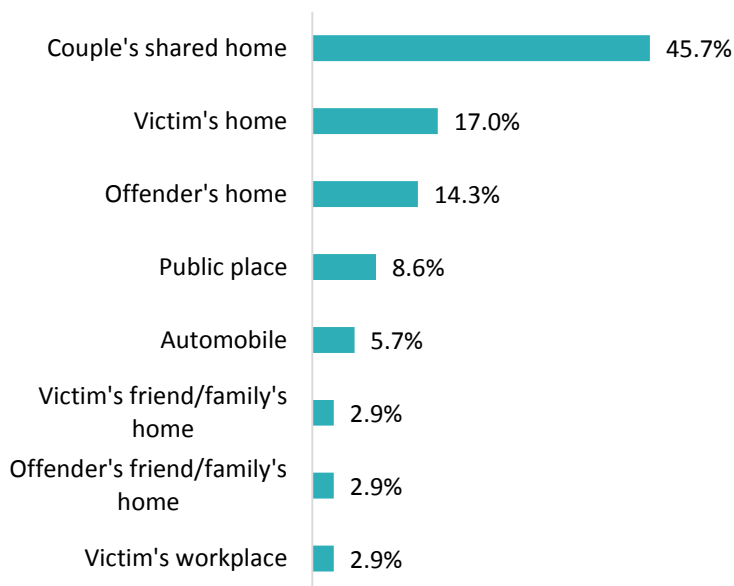
Media articles⁵

⁵ Sparkman, A. (2010, October 4). Alleged murder-suicide leaves a husband & wife dead. WKYT. Retrieved from: <http://www.wkyt.com/news/headlines/104307239.html?ref=239>.

Location of Homicide. The location of the homicide for the 35 cases is presented in Figure 5. The homicide took place at the victim and offender’s shared residence in 45.7% of the cases. Victims were murdered in their own home in 17.0% of cases and at the offender’s home in 14.3% of cases. Three victims were murdered in public places (8.6%) including a parking lot, a yard outside of a home, and in the woods. Two homicides occurred in an automobile (5.7%). One homicide occurred at the victim’s family or friend’s home, one homicide occurred at the offender’s family or friend’s home, and one homicide took place at the victim’s workplace.

Almost half of the homicides occurred at the victim and offender’s shared residence.

Figure 5. Location of homicide (n = 35)¹



¹Media reports were used for 10 cases

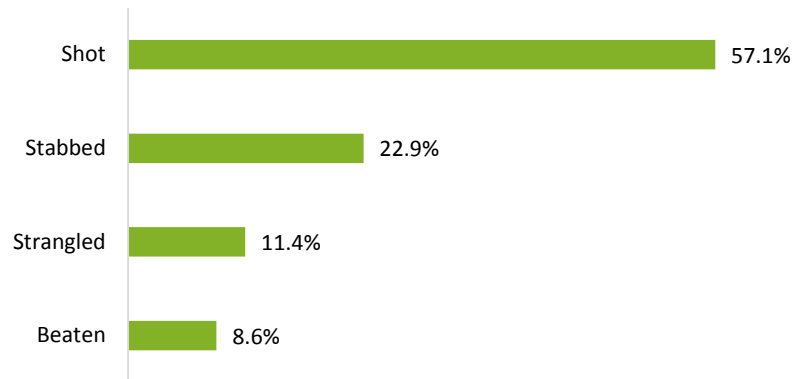
Offender told a man who lived near his mobile home, “I sliced her from ear to ear and put her in a trash bag in the bathroom”...Her body was found in a container in his home...Unable to dig a grave alone, offender recruited the help of a friend, who later called the police.

- **Media articles⁶**

⁶ Kocher, G. (2011, May 19). Man who killed girlfriend agrees to maximum penalty instead of trial. *Lexington Herald-Leader*. Retrieved from: http://www.kentucky.com/2011/05/19/1744884_man-who-killed-girlfriend-agrees.html?rh=1.

Weapon. Overall, 57.1% of victims were shot, 22.9% were stabbed, 11.4% were strangled, and 8.6% were physically beaten or beaten with an object (Figure 6).

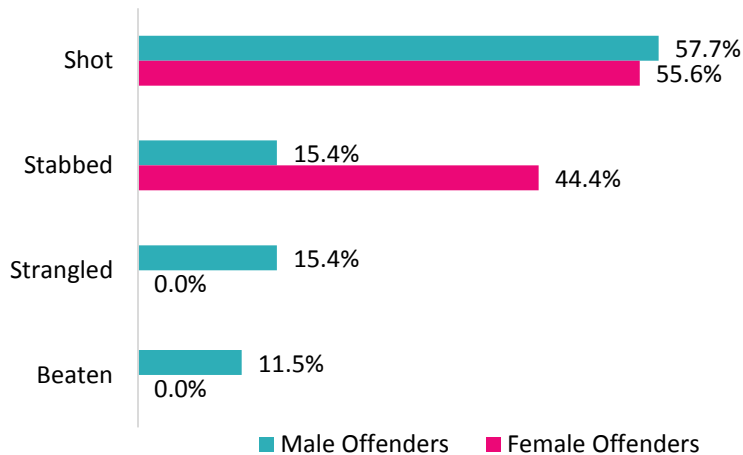
Figure 6. Method of homicide (n = 35)¹



¹Media reports were used for 9 cases

Female offenders most often shot (55.6%) or stabbed (44.4%) their victim (Figure 7). Male offenders also most often shot (57.7%) their victim but also used a variety of other methods including stabbing (15.4%), strangling (15.4%), and beating (11.5%) their victim to death.

Figure 7. Method of homicide by offender gender (n = 35)¹



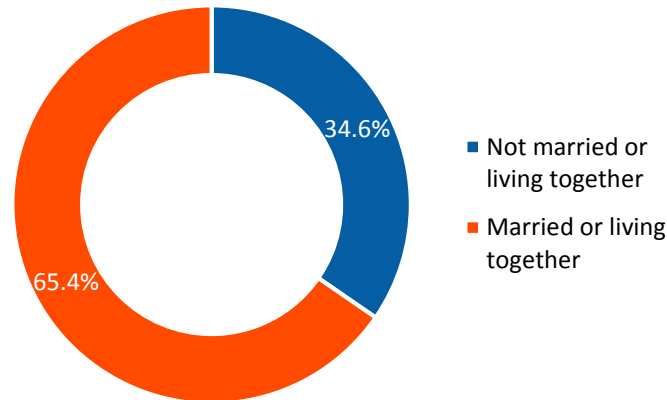
¹Media reports were used for 9 cases

Conceal Carry License. Kentucky State Police checked all intimate partner offenders and victims in the 35 cases on whether they had a Conceal Carry License. No victim or offender had a Conceal Carry License.

Victim and Offender History

Relationship Status. Information on whether the victim and offender were married or living together at the time of the homicide was missing for one-quarter of the cases (n = 9). Of those with information available (n = 26), 65.4% were married or living together at the time of the homicide (Figure 8).

Figure 8. Married or living together at the time of homicide (n = 26)



Offender broke into the home of his ex-girlfriend as she and her new partner were sleeping. His ex-girlfriend had more than 92 stab wounds and bruises all over her body. Her new partner had injuries to his lungs but survived. The stabbing took place with their young son crying in the next room.

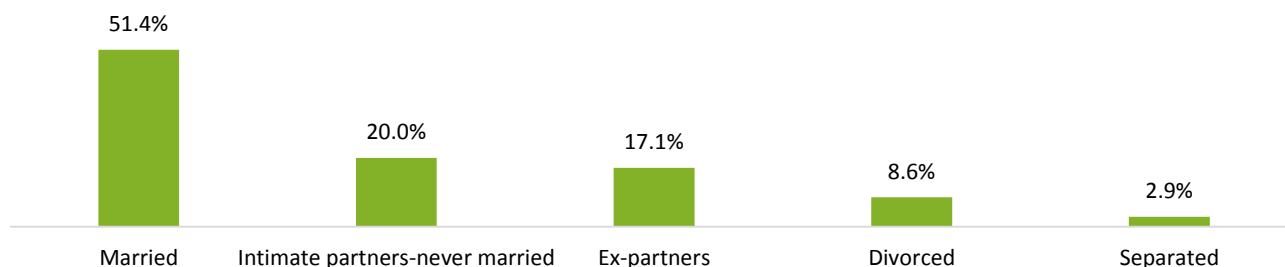
- **Media articles**^{7,8}

As reported in the survey or from media articles, 51.4% of the victims were married to the offenders at the time of the homicide, about 20% were current non-marital intimate partners, and 17.1% were ex-boyfriends or ex-girlfriends (Figure 9). Also, 8.6% of the victims were killed by an ex-spouse with whom they were divorced and 2.9% of victims were killed by a spouse with whom they were separated but not yet divorced at the time of the homicide.

⁷ MacDonald, J. (2011, June 07). Defense admits to killing ex-girlfriend, calls it manslaughter. *Wave3 News*. Retrieved from: <http://www.wave3.com/story/14851643/opening-statements-in-trial-of-man-accused-of-brutally-murdering-ex-girlfriend>.

⁸ Recommended Sentence for Nicholas Salfi (2011, June 27). Recommended sentence for Nicholas Salfi: 40 years for murder. *WDRB*. Retrieved from: <http://www.wdrb.com/story/14904262/sentencing-hearing-for-nicholas-salfi>.

Figure 9. Relationship between victim and offender (n = 35)¹



¹Media reports were used for 6 cases

Children in Common. Of cases with information available regarding children in common or victim pregnancy (n = 24), 37.5% had minor (i.e., under 18) children in common (Table 3). None of the female victims were pregnant at the time of the homicide.

Table 3. Percentage of victims who had minor children in common with their offender

Children in Common	
Victim and offender had minor children in common	N = 24
No	62.5%
Yes	37.5%

Domestic Violence-Related Civil and/or Criminal Justice System Activity. Based on the information provided by the surveys and Kentucky State Police, 25.7% of cases had some domestic violence related civil and/or criminal justice activity (i.e., had an active Domestic Violence Order, a request for an Emergency Protective Order, an active No Contact court order, or a domestic violence-related call to police) within one year prior to the homicide⁹. Overall, 11.4% of the cases had some form of domestic violence related civil and/or criminal justice activity within 30 days of the homicide.

1 in 4 cases had some domestic violence-related criminal and/or civil justice system activity 12 months prior to the homicide.

Protective Orders. The Kentucky State Police provided information on protective order history. Overall, about one-quarter (25.7%, n = 9) of the cases involved a victim or offender who had ever filed an Emergency Protective Order (EPO) only or was granted a Domestic Violence Order (DVO) in Kentucky

⁹ Of the seven cases with domestic violence-related activity the year prior to the homicide, two cases involved an EPO only, one case involved both an EPO and an active No Contact Order, one case involved a DVO, domestic violence-related call to police, and an active No Contact Order, and three cases involved domestic violence calls to police only. All but one of these cases involved a female victim. In the case of the male victim, a domestic violence call to police was made within one year of the homicide.

(Table 4). Kentucky State Police records showed that 11.4% of cases had ever only filed an EPO (not granted a DVO) and 14.3% had ever been granted a DVO.

Of those with a DVO (n = 5), 40% (n = 2) were active at the time of the victim's death, one expired about nine years prior to the homicide and two had expired within 6 months of the death. Of those with an EPO only (n = 4), 50% (n = 2) had been requested within 30 days prior to the homicide.

Information from the Kentucky State Police also indicated that one offender with an EPO filed against him and two offenders with a DVO against them were flagged in the LINK system as armed and dangerous.

None of the male homicide victims had an EPO or DVO. Conversely, two of the nine female offenders and seven of the female victims had a history of protective orders against their male partner.

No Contact Orders. Only 21 cases had survey information regarding No Contact Orders. Of those cases, 9.5% of victims were reported as having an active criminal court No Contact Order in place against the offender in addition to an EPO or DVO at the time of the homicide (see Table 4). Of those victims with a No Contact Order, one victim also had an active DVO granted against the offender. Another victim with a No Contact Order had filed for an EPO against the offender in the 30 days prior to her death.

Offender was charged with murdering his wife and mother of their young son. She died after her throat was cut in a hotel room. There was a long history of the offender being violent to the victim and she had two protective orders against her husband in the past.

- [Media articles¹⁰](#)

Domestic Violence Calls to Police. Of the surveys with information provided about domestic violence calls to the police (n = 20), 60% of cases had no record of a domestic violence call to the police (Table 4). Twenty-five percent had made a call to the police within 12 months of the homicide (5% within 30 days and 20% within 12 months) and 15% had made a domestic violence-related call to police more than a year before the homicide.

¹⁰ Chrisos, J. (2010, August 11). Court documents show violent history between couple. *Wave3 News*. Retrieved from: <http://www.wave3.com/story/12962638/court-documents-show-violent-history-between-couple>.

Table 4. Protective Order, No Contact Orders, and domestic violence calls to police

Protective Order history ¹	N = 35
None	74.3%
EPO filed only (no DVO) (n = 4)	11.4%
Requested within 30 days prior to the homicide (n = 2)	5.7%
Requested years earlier (n = 2)	5.7%
DVO (n = 5)	14.3%
Active at the time of victims death (n = 2)	5.7%
Expired within 6 months of the death (n = 2)	5.7%
Expired years earlier (n = 1)	2.9%
Active criminal court No Contact Order in place at time of homicide	N = 21
No	89.5%
Yes	9.5%
Previous domestic violence calls to police	N = 20
None noted	60%
More than 12 months before homicide	15%
Within 12 months of homicide	20%
Within 30 days of homicide	5%

¹EPO = emergency protective order; DVO = domestic violence order

History of Partner Abuse and Violence from Media Articles

Overall, a history of domestic violence, abuse, and/or protective orders involving the homicide victim and offender were mentioned in media articles for 51.4% of the cases (see Table 5).

When examining media articles for cases with male offenders (n = 26), 42.3% mentioned that the male offender perpetrated domestic violence or abuse against the female victim prior to the homicide and one article mentioned domestic violence between the offender and the offender's ex-wife (not the homicide victim). No media articles in the cases involving a male offender mentioned that the female victim perpetrated domestic violence or abuse in the past or that there was mutual violence.

When examining media articles with female offenders (n = 9), none of the articles mentioned that the female offender solely perpetrated domestic violence, abuse, or control against the male victim. None of the articles mentioned female perpetrated abuse toward other partners. However, 55.6% of the cases mentioned that the male homicide victim perpetrated domestic violence, abuse, or control against the female homicide offender in the past. And, two articles suggested there was mutual violence (22.2%) between the female offender and male victim.

Domestic violence history was most often mentioned as male perpetrated regardless of whether the female was the homicide victim or the homicide offender.

Offender was sentenced in the stabbing death of his son's mother. The victim was 25 years old and the couple's 2-month old baby and the offender's 5 year old daughter witnessed the stabbing. Neighbors say the couple frequently argued. He was controlling. He didn't want her to be around her friends and family; he wanted her only to be around him.

- **Media articles^{11,12}**

Table 5. History of partner abuse and violence from media articles

	Male Offender N = 26	Female Offender N = 9
Offender to victim abuse mentioned	42.3%	0%
History of abuse with other victims mentioned	3.8%	0%
Victim to offender abuse mentioned	0%	55.6%
Mutual violence mentioned	0%	22.2%

Offender Case Status

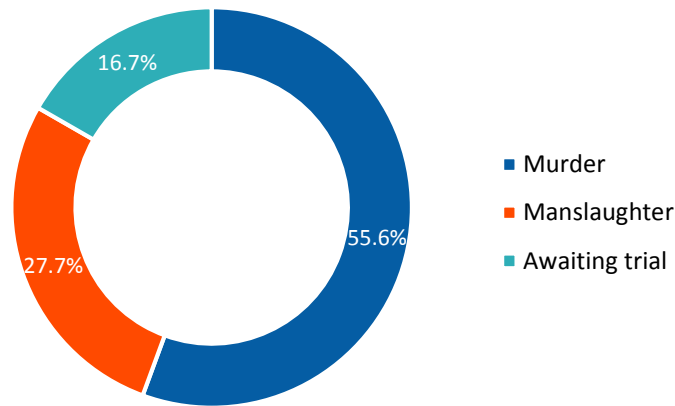
One female offender case was ruled self-defense. Thirty-seven percent of offenders committed suicide after the homicide and were consequently not charged.

Case Status. Of the offenders who were not deceased or not charged and information was available (n = 18), 55.6% were convicted of first-degree murder and 27.7% were convicted of first or second-degree manslaughter (Figure 10). The remaining three offenders (16.7%) were awaiting trial and no information was made available regarding the charges.

¹¹ Man Stabs Girlfriend to Death (2010, Nov 22). Man stabs girlfriend to death with their newborn and 5 year-old in house. *Women's Self Defense Federation*. Retrieved from: <http://womensselfdefensefederation.com/man-stabs-girlfriend-to-death-with-their-newborn-and-5-year-old-in-house>.

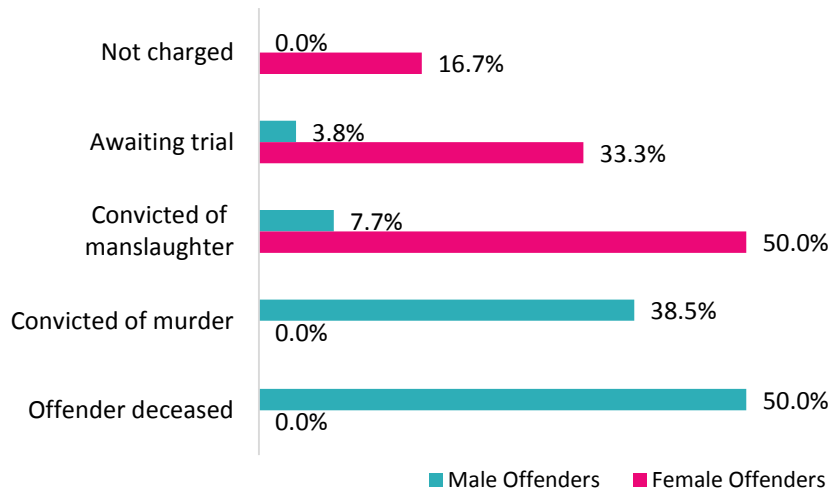
¹² Police: Daughter Witnessed Murder (2010, Nov 24). Police: Daughter witnessed mother's murder. *Fox 19*. Retrieved from: <http://www.fox19.com/story/13544496/woman-found-dead-in-dayton-kentucky>.

Figure 10. Offender case status (n = 18)



No female offenders were convicted of first-degree murder (see Figure 11). Slightly more females (n = 3) versus males (n = 2) were convicted of manslaughter and three females versus one male were awaiting trial at the time the survey was completed.

Figure 11. Offender case status by gender (n = 32)¹



¹Media reports were used for 3 cases

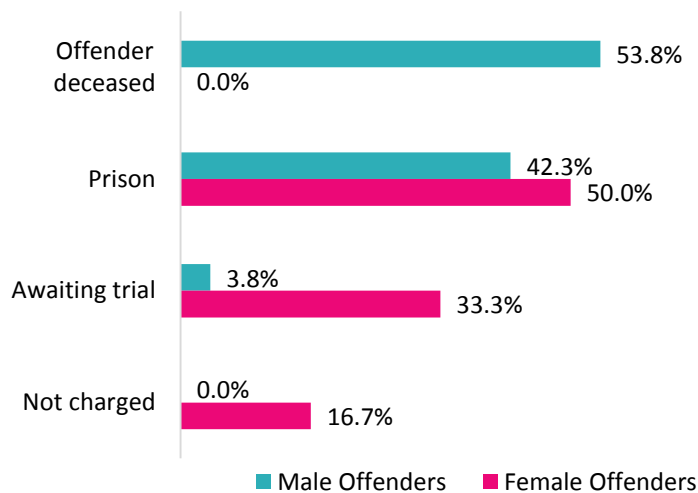
Female offender was facing a murder charge for shooting her former boyfriend but prosecutors reduced the charge in light of evidence that the homicide victim was violating a protective order barring him from seeing her when she shot him.

- **Media articles¹³**

¹³ Taylor, Chris. (2011, January 25). Murray woman pleads guilty to manslaughter. *WKMS*. Retrieved from: http://www.publicbroadcasting.net/wkms/news.newsmain?action=article&ARTICLE_ID=1753794.

Current Offender Status. Information regarding the most recent offender status was available for 32 of the 35 cases (Figure 12). At the time the survey was completed, none of the female offenders and 53.8% of the male offenders were deceased (13 of the male offenders committed suicide at the time of the homicide and one male offender died in prison). Half of the female offenders and 42.3% of the male offenders were in prison at the time of the survey. Further, 3.8% of the male offenders and 33.3% of the female offenders were awaiting trial and none of the male offenders and 16.7% of the female offenders were not charged at the time the survey was completed.

Figure 12. Current offender status by gender (n = 32)¹



¹Media reports were used for 3 cases

Victim was getting her hair cut when her ex-husband stormed in, shouting at her, and begging her to take him back. She told him she could not take him back and that this wasn't the place to have a discussion about it. As she walked to her car he shot her eight times. He wasn't satisfied. So he ran home to retrieve his rifle and sprinted back to the beauty shop. He pumped, shot, and repeated. Fifteen more times.

- **Media articles**^{14,15}

¹⁴ Tonja Slone Gunned Down (2010, April 27). Tonja Slone gunned down by "crazy" Dave. *Maidens, Murder, and Mayhem*. Retrieved from: <http://maidenmurder.wordpress.com/2010/04/17/tonja-slone-gunned-down-by-crazy-dave/>.

¹⁵ Sparkman, Angela (2010, April 13). Floyd County murder suicide. *WKYT*. Retrieved from: <http://www.wkyt.com/home/headlines/90715249.html>.

SUPPLEMENTARY HOMICIDE REPORT (SHR) CASE IDENTIFICATION

As part of the FBI's Uniform Crime Reporting System, the Supplementary Homicide Report (SHR) data are collected and submitted in each state by local law enforcement. There are limitations with this data collection as not all cases may be reported in the SHR data and not all victim-offender relationships are reported (or are accurately characterized) even when a homicide is reported. Additionally, information may be submitted before a complete investigation, autopsy, and prosecution occurs, therefore any changes to the initial classification of the death (e.g., homicide or accidental) and to the relationship status would not be reflected in the data.

Furthermore, the SHR does not include non-married ex-intimates (e.g., ex-girlfriend) as a category of intimate partners. This means that only cases that classified the victim-offender relationship as a boyfriend, girlfriend, common-law husband, common-law wife, same-sex relationship, husband, wife, ex-husband, and ex-wife are included. Additionally, the SHR only provides victim-offender information for one victim and up to eleven offenders associated with that victim. That means that if it is a multiple-victim homicide, more detailed characteristics are included for only one victim and how that victim is chosen is not clear.

Within these limitations, the following section describes the number and characteristics of intimate partner-related homicides in Kentucky for 2010 (SHR Cases), along with a Trend Analysis examining Kentucky intimate-partner related homicides reported in the SHR for six years (2006-2011).

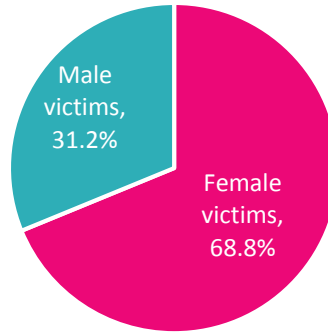
In 2010, there were 189 total homicide deaths reported in the SHR database for Kentucky. Given that some of these deaths involved multiple-victim homicides, the 189 deaths represent 176 homicide *cases* in Kentucky in 2010. It is important to note that the relationship between the victim and offender was undetermined for 31.9% of the 176 cases, which is consistent with the proportion of cases with undetermined victim-offender relationships nationally (Bureau of Justice Statistics, 2011).

Of the 120 Kentucky homicide cases in 2010 with an identified victim-offender relationship, there were 32 cases classified as intimate partner-related. All 32 intimate partner homicide cases were classified as murder or non-negligent manslaughter and were all single-victim homicides.

SUPPLEMENTARY HOMICIDE REPORT (SHR) CASE CHARACTERISTICS

Of the 32 intimate partner-related homicide cases, the majority of victims were female (68.8%) with less than one-third male (Figure 13).

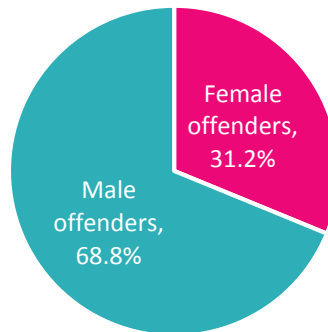
Figure 13. Victim gender



Consistent with the Statewide Cases, the majority of victims were female and the majority of offenders were male.

The majority (68.8%) of offenders were male (Figure 14).

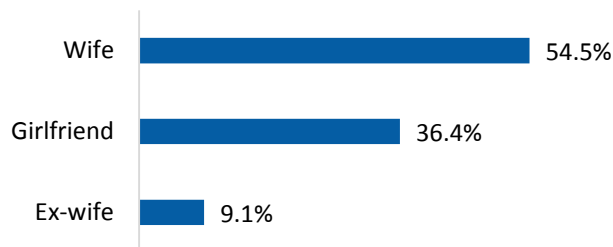
Figure 14. Offender gender (n = 32)



As shown in Figure 15, the majority of the 22 female victims (54.5%) were classified as a wife, 36.4% were classified as a girlfriend, and 9.1% were classified as an ex-wife of the offender.

For male victims (n = 10), half were classified as a boyfriend and half were classified as a husband.

Figure 15. Female Victims: Victim-offender relationship (n = 22)



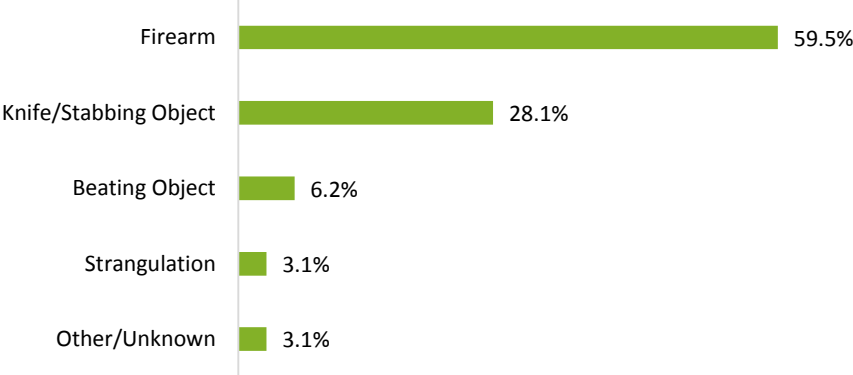
The majority of victims and offenders were white and a small proportion were black (Table 6). The average age of the victims was 45 years old, ranging from 21 to 84, and the average age of offenders was 45 years-old ranging from 22 to 92.

Table 6. Victim and offender race

Race	N = 32
Victim	
White	87.5%
Black	9.4%
Unknown	3.1%
Offender	
White	87.5%
Black	12.5%

Close to 60% of the homicides involved firearms (Figure 16). Also, 28.1% of victims were stabbed with a knife or other object, 6.2% were beaten to death, and one victim was strangled. One case did not include information about how the victim was killed.

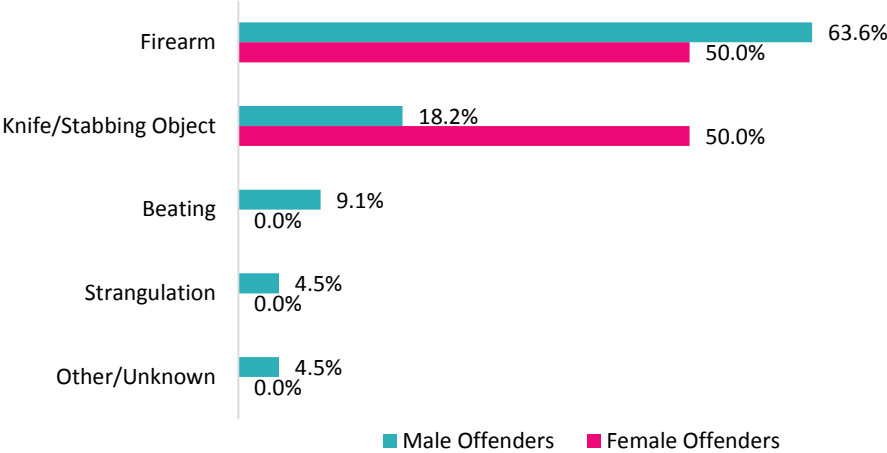
Figure 16. Weapon (n = 32)



As Figure 17 shows, the majority of offenders, regardless of gender, used firearms to kill their (ex) partner. More females stabbed their victim than males while only males beat or strangled their victims.

The majority of offenders, regardless of gender, used firearms to kill their (ex) partner.

Figure 17. Weapon by gender (n = 32)



SHR CASE TREND ANALYSIS

The SHR data were examined for intimate partner-related homicides in Kentucky for the calendar years 2006 through 2011. Any relationship between the victim and any of the offenders labelled as boyfriend, girlfriend, common-law husband, common-law wife, same-sex relationship, husband, wife, ex-husband, and ex-wife were considered intimate partner-related homicides.

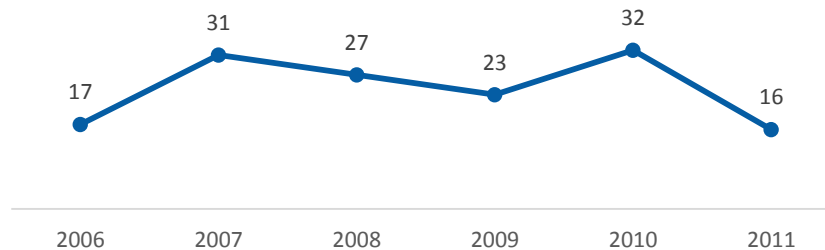
Intimate partner-related homicides in Kentucky from 2006 – 2011 were relatively stable over time

On average across the six years, the relationship between the victim and primary offender was not determined in about 31% of homicide cases in Kentucky.

The number of intimate partner-related homicide cases in Kentucky was lowest for 2006 and 2011 and the highest for 2007 and 2010 (Figure 18). Results suggested that intimate partner-related homicides in Kentucky

were relatively stable over time.

Figure 18. Number of intimate partner-related homicides in Kentucky from 2006-2011



CONCLUSION AND LIMITATIONS

Intimate partner violence has been identified as a serious but preventable public health problem affecting a significant number of Kentucky women and girls (Black et al., 2011). Every year, at least 1 in 6 murder victims are killed by an intimate partner, with close to 1 in 2 females and 1 in 20 males murdered by an intimate partner (Bureau of Justice Statistics, 2011).

Overall, 35 Kentucky intimate partner-related homicide cases, with a total of 40 deaths, were identified for 2010 through the Office of the Chief Medical Examiner and through media articles. Results showed that the majority of victims were female and the majority of offenders were male which is consistent with other Kentucky (Logan & Faragher, 2013; Louisville Metro Domestic Violence Prevention Coordinating Council, 2013) and national (Bureau of Justice Statistics, 2011) intimate partner homicide trends.

The majority of cases were single victim homicides and 37% involved murder-suicide, all of which were male offenders. Firearms were most frequently used regardless of offender gender which is also consistent with other research on intimate partner fatalities (Bureau of Justice Statistics, 2011; Logan & Faragher, 2013; Louisville Metro Domestic Violence Prevention Coordinating Council, 2013; Moracco, Runyan, & Butts, 1998; Vittes & Sorenson, 2008) and research on the increased risks for homicide and suicide when a gun is in the home (Anglemyer, Horvath, & Rutherford, 2014; Kellermann et al., 1993; Wiebe, 2003). Research examining multiple risk factors for homicide find especially high risk when domestic violence and a readily available firearm were present (Bailey et al., 1997).

Overall, 2 in 3 victims and offenders were married or living together at the time of the homicide and the homicide occurred most frequently at the couple's shared residence (45.7%) which is consistent with prior research (Vittes & Sorenson, 2008). Almost 2 out of 5 victims had minor children in common with the offender and no victims were pregnant at the time of the homicide.

Overall, 1 in 4 cases had some form of domestic violence-related civil and/or criminal justice activity (i.e., a protective order, active No Contact court order, or domestic violence-related call to police) within the year prior to the homicide and 1 in 9 had some domestic violence-related civil and/or criminal justice activity within 30 days of the homicide. Specifically, in about 6% of the cases the female partner had an active protective order against the male partner which is consistent with other research that found 6% of women killed by an (ex) partner had obtained a protective order against the offender within 12 months of their death (Morocco et al., 1998). Overall, in 14.3% of cases the female partner had ever had a DVO against the male partner which is also consistent with other studies that have found 11.3% of women murdered by their intimate partner had a protective order against that partner at some point (Vittes & Sorenson, 2008).

Male perpetrated violence and abuse was exclusively mentioned in media articles for about half of male offender cases and just over half of the female offender cases, but female perpetrated abuse and violence was not mentioned in any case. In two female offender cases, the media articles mentioned mutual violence between the offender and victim.

The 2010 Supplementary Homicide Report (SHR) data for Kentucky supported findings from the Statewide Domestic Violence Fatality Information Survey. The majority of victims were female, the majority of offenders were male, and a firearm was used most frequently to kill their partner. Examining intimate partner-related homicides over a six year period suggests intimate partner-related homicides are not declining over time in Kentucky. This is consistent with national data that suggests the percent of males killed by an intimate partner from 1980 to 2008 fell by 53% while the percent of females killed by an intimate partner for that same time period rose by 5% (U.S. Bureau of Justice Statistics, 2011).

This report provided a first step toward understanding how to identify intimate partner-related homicides in Kentucky as well as information to better understanding the scope and nature of these intimate partner-related homicides. However, there are several significant limitations as described below.

Under-Identification of Intimate Partner-Related Homicides in Kentucky. Two different procedures for identifying intimate partner homicides in 2010 were used and the number of cases identified in both procedures was relatively close (35 Statewide Cases and 32 SHR Cases). However, there are limitations in identifying cases in both procedures as described below:

- Same-sex couples may not be classified as intimate partners in media or other reports (e.g., police), but rather as friends, acquaintances, or roommates.
- Deaths that are intimate partner-related but the relationship between those involved is not straightforward may not be classified as an intimate partner-related homicide. For example, a case in which an ex-partner of a woman killed her new partner but not her would not necessarily be classified as an intimate partner-related homicide.
- When there are multiple victims, identification and collection of case characteristics become more difficult. For example, media reports were inconsistent in these cases. Also, the SHR only reports victim-offender relationship for one victim. It is not clear how the primary victim is chosen.

Tracking case information on a statewide basis would highlight patterns and provide information that may help protect intimate partner violence victims and their children who are at a higher risk of being murdered by an abusive partner.

- The relationship between victim and offender may not always be clear when reported in the media, medical examiner reports, and SHR. For example, a dating couple may be classified as friends, acquaintances, or roommates. Additionally, about one-third of the homicide cases in the SHR classified the victim-offender relationship as unknown.
- The SHR data does not include ex-boyfriends and ex-girlfriends as intimate partners.
- Although the majority of law enforcement agencies in the United States participate in the Uniform Crime Report SHR data collection (Bureau of Justice Statistics, 2012), it is unclear how consistently the agencies report crime data. With regard to the SHR data, the participation of reporting varies by state and by year. Some states reported SHR data consistently every year while others have very seldom reported this data over the past 20+ years (U.S. Department of Justice, 2013). For example, the SHR Cases for 2010 did not include any homicides from Lexington police and only included 5 from Louisville Metro which is inconsistent with the Statewide Case identification.

Missing Information about Case Characteristics. Surveys were requested for each of the 37 victims and seven surveys were not completed. For the 30 surveys that were completed, there was missing data on a variety of questions. Missing data poses problems with estimating the nature and context of intimate partner homicide. Consequently, the Office of the Chief Medical Examiner, Kentucky State Police, and media articles were used to supplement the information.

Fatality reviews can highlight community system strengths and weaknesses in addressing partner and family violence and help identify opportunities to increase safety for victims and accountability for offenders.

Reliability of Survey Information. The surveys were completed by individuals in the county of the death who may have had limited access to information about the case. There were specific cases where no or very little information was available, which further limits the findings in this report (e.g., cases with murder-suicides). Also, a single agency may not check all sources of information (e.g., civil and criminal history, police reports), may not be able to access the relevant information, and may not have resources to bring various agencies together to discuss these cases in order to obtain specific case characteristics. In addition to problems with accessing information, there may also be concern related to interpreting case information and translating this to the survey. For example, the process of leaving an abuser, given the dynamic of abusive relationships, can include an on and off relationship and/or living arrangements, making it very difficult to determine the relationship status between victim and offender. Also, the survey wording and

questions can use improvement to get more accurate and reliable data.

Limited Information about Cases. There was limited case information collected, leaving more questions than answers. For example, obtaining a complete history of domestic violence along with risk factors and missed opportunities from reliable sources will help create more accurate knowledge

of the patterns involved in intimate partner homicide cases in Kentucky. It is recommended that, at a minimum, criminal histories be included as part of the basic case characteristics to examine domestic violence charges and convictions for offenders and victims.

Labor Intensive. The procedures used to identify Statewide Cases and to gather case characteristics were labor intensive. An effort to maintain surveillance and gathering of case characteristics will require additional labor and resources.

Intimate partner homicide is a tragic but preventable crime. The limitations discussed in this report suggest there is a need for more effective tracking and monitoring of intimate partner homicide data in Kentucky. Tracking case information on a statewide basis would highlight patterns and provide information that may help protect intimate partner violence victims and their children who are at a higher risk of being murdered by an abusive partner. Fatality reviews can highlight community system strengths and weaknesses in addressing partner and family violence and help identify opportunities to increase safety for victims and accountability for offenders.

Offender is accused of killing his wife. Neighbors say the couple was fun-loving and seemed to have no quarrels.

- **Media articles**¹⁶

¹⁶ Kocher, G. (2010, October 21). Retired Lexington fire captain, wife die in apparent murder-suicide. *Lexington Herald-Leader*. Retrieved from: http://www.kentucky.com/2010/10/21/1488068_mercer-couple-found-dead-in-home.html?rh=1.

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APPENDIX A
STATEWIDE DOMESTIC VIOLENCE FATALITY INFORMATION SURVEY

Statewide Domestic Violence Fatality Information for 2010 Cases Commonwealth of Kentucky Attorney General Special Project

Thank you for your help with this project. It has come to our attention that Domestic Violence Fatalities are a significant issue nationally and within the Commonwealth, however, very little information has been collected systematically to even answer basic questions. The Attorney General's office has taken a special interest in this information to help improve the health and welfare of the citizens of Kentucky but also to highlight the exceptional and difficult work that law enforcement and prosecutors do on a regular basis. We want to **highlight and acknowledge your efforts as well as to draw attention to the issue of domestic violence homicides and find ways to address and prevent domestic violence in communities before they come to this kind of tragic ending.** Your office and specific information will not be identified in any way. We will report this information as a statewide issue and potentially by county or state region.

Please send completed form or direct questions to Allyson Taylor (Phone) 502-696-5320 (Fax) 502-696-5532 (email) Allyson.taylor@ag.ky.gov.

BACKGROUND INFORMATION

This information was obtained from the Medical Examiner's Office or through media reports. Please correct any information that you believe is noted incorrectly.

Victim Name: _____

Age at the time of the incident: _____

Gender 1=Female 2=Male

Race/Ethnicity:

1=White

2=Black

3=Hispanic

4=Other (Specify): _____

Date of Autopsy: _____

County of Coroner: _____

INFORMATION NEEDED

The information needed about the case referenced above is being collected from agencies across Kentucky for all identified 2010 cases of domestic violence or suspected domestic violence homicides.

1. Victim relationship to offender

1=Married

2=Divorced

3=Separated (not yet divorced)

4=Living together at the time of incident but were never married

5=Had lived together in the past, but were never married

6=Dating

7=Unknown

8=Other (Specify): _____

2. Did victim have children under 18 in common with offender? 0=NO 1=YES 2=SUSPECTED

3. Victim was pregnant at the time of the incident?

0=NO

1=YES

2=N/A Male Victim

3 = UNKNOWN

4. Were the parties married or living together at the time of the homicide?

0=NO

1=YES

2=SUSPECTED

5. Length of relationship with offender: _____ Years (as best as you can tell)

6. Was there an active EPO or DVO in place at the time of the homicide? 0=NO 1=YES, EPO 2=YES DVO

6a. If yes, had that EPO/DVO been served at the time of the homicide? 0=NO 1=YES

7. Had an EPO/DVO been requested within 30 days of the homicide? 0=NO 1=YES

8. Was there an active criminal court No Contact Order (Pre-trial Release Order)? 0=NO 1=YES

9. Had there been any previous DV calls to police for this victim and offender?

1. Never
2. Yes, more than 12 months preceding the incident
3. Yes, within 12 months of the incident
4. Yes, within 1 month of the incident

10. Type of case:

1=Homicide

2=Homicide/suicide

3=Multiple victims

4=Other (specify): _____

11. Date of death: _____

12. Place of death

1. Her home
2. His home
3. Their shared residence
4. Public place
5. Automobile
6. Her relatives/friends home
7. His relatives/friends home
8. Other (specify): _____
9. Unknown

13. County of death: _____

14. Mode of Homicide

1. Gunshot a=handgun b=rifle c=shotgun d=other (specify): _____
2. Stabbing
3. Beat with an object
4. Physical beating, choking, pushing, etc
5. Other (specify):

14a. Victim was also:

1. Physically beaten
2. Strangled
3. Sexually assaulted
4. Other (specify): _____

15. Total number of victims who died at or during the incident (including the primary domestic violence victim and the offender in cases of suicide by the assailant): _____

15a. Other deaths

1. Children
2. Her other partner
3. Her friend/acquaintance
4. His friend/acquaintance
5. Her coworkers/supervisor/someone at the job site
6. His coworkers/supervisor/someone at the job site
7. Neighbors
8. Bystanders
9. Other (specify): _____

16. Total number of victims non-fatally wounded: _____

16a. Non-fatal wounding of others

1. Children
2. Others

17. Offender name: _____

18. Offender age at the time of the incident: _____

19. Gender of offender: 1=Female 2=Male

20. Offender Race/Ethnicity:

- 1=White
2=Black
3=Hispanic
4=Other (Specify): _____

21. Convicted for the homicide: 0=NO 1=YES (If yes, please indicate charge)

1. Murder
2. Manslaughter First Degree
3. Manslaughter Second Degree
4. Reckless Homicide
5. Not charged
6. N/A (offender deceased)
7. Other

22. Offender status

1. Deceased
2. Awaiting trial
3. Acquitted
4. Prison
5. Probation/Parole
6. Other (specify): _____

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Contact information for person completing this form:

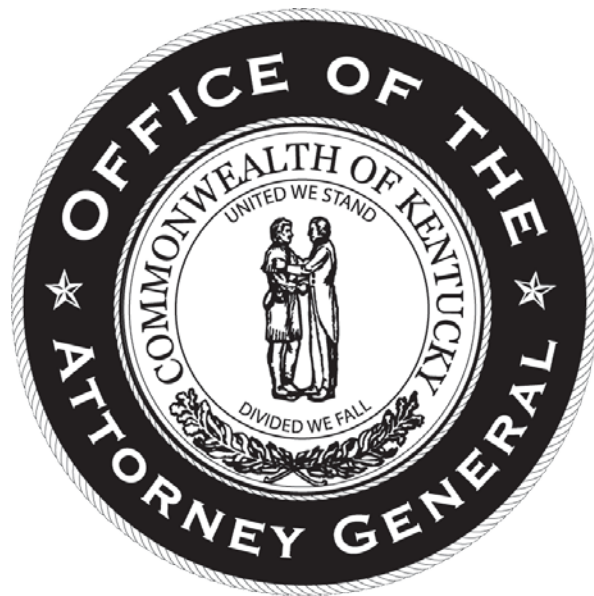
Name _____

Title _____

Agency _____

Telephone # _____

Email address _____



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