REPORT TO THE GOVERNOR, SUPREME COURT, ATTORNEY GENERAL, AND GENERAL ASSEMBLY

IOWA DOMESTIC ABUSE DEATH REVIEW TEAM

Biennial Report

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FOREWORD

The Iowa Domestic Abuse Death Review Team was created in 2000 to review domestic abuse- related homicides and suicides in the state. Legislative authorization is given in the *Code of Iowa* Chapter 135.108 and in the *Iowa Administrative Code* 641-91. The specific purpose of the team is "…to aid in the reduction of the incidence of domestic abuse deaths by accurately identifying the cause and manner of deaths occurring from domestic violence and by making recommendations for changes in policy and practice to improve community interventions for preventing domestic abuse deaths." A domestic abuse death means a homicide or suicide that involves or is a result of an assault as defined in section 708.1 *(Iowa Code*) and the parties involved were:

- current, separated, or former spouses,
- current or former co-habiting partners,
- parents of the same minor children,
- current or former dating partners,
- related by blood or affinity to someone in the same household or workplace, or
- subject to an order of protection between the perpetrator and victim.

The team meets four to six times per year, and members are appointed by the director of the Department of Public Health in consultation with the Attorney General. The Chief Justice of the Iowa Supreme Court appoints two team members. There are nine government agency liaisons assigned to the team, who also serve as full team members. Administrative support is provided by the Department of Public Health.

The team responsibilities include:

1. Preparing a biennial report for the governor, supreme court, attorney general, and the general assembly concerning:
   - The causes and manner of domestic abuse deaths, including an analysis of factual information obtained through review of domestic death certificates and domestic abuse death data,
   - The contributing factors of domestic abuse deaths, and
   - Recommendations regarding the prevention of future domestic abuse deaths, including actions to be taken by communities.
2. Advising and consulting the agencies represented on the team regarding program and regulatory changes that may prevent domestic abuse deaths.
3. Developing protocols for domestic abuse death investigations and team review.

The case reviews done by the team focus on reviewing the circumstances that occurred in the relationship between the intimate partners that led up to the death(s); including contact the couple may have had with the criminal justice system, community professionals, or other community systems. This is done to determine what risk factors may have been present to indicate lethality and if there were prior opportunities for intervention.

The type of records requested for each case include: newspaper articles, birth and death certificates, autopsy reports, law enforcement investigative reports, 911 call logs, arrest histories, court records, crime victim assistance applications, corrections files, medical records, victim service records, and school or protective services records when children are involved. The findings are based on the information that is documented in the records received, and not all records are received for each case.

Additional note: As a matter of consistency, the team has chosen to use the term "domestic violence" throughout the report to refer to the physical and emotional behaviors used by an intimate partner against the other in an attempt to control the partner's actions and maintain the relationship.

STATUS OF PRIOR YEAR RECOMMENDATIONS

The status of recommendations made during prior years (in italics) were tracked for completion. In April 2006, the Iowa General Assembly made amendments to the legislation requiring state agencies to respond within 30 days after notification of recommendations. This is the first report issued since that legislation took effect in July 2006.

Recommendation to Communities

- *Family & friends should take domestic violence seriously and report it to police or contact the statewide hotline.* During state fiscal year (FY)2007, the most recent year for which data are available, 17,655 women received services from domestic violence programs across the state and 1,232 calls were made to the Iowa Domestic Abuse Hotline. There were 7,069 reports of domestic violence made to law enforcement during calendar year 2007.
- *Community professionals should be adequately trained to identify domestic violence and what resources are available to serve victims and perpetrators.* Designated state trainers from the Iowa Attorney General's Office, Iowa Coalition Against Domestic Violence, Iowa Department of Public Health, Iowa Law Enforcement Academy, and Supreme Court Administrator's Office conducted training sessions on domestic violence to 7,263 community professionals in FY08; in FY09, 4,728 received training. Local domestic violence service programs also conduct training in their communities upon request; during FY07, another 12-13,000 professionals received training locally.

Recommendations to State Agencies

Iowa Legislature

- *Support passage of legislation prohibiting those convicted of misdemeanor domestic violence or subject to a protective order from possessing firearms.* This bill has not been passed since it was initially proposed in 2002.
- *There should be adequate resources for domestic violence services and shelters*. In the face of declining federal funds and severe state budget shortfalls, the Legislature eliminated the line item for funding to support local domestic abuse and sexual assault service programs during the 2002 Legislative session. The Attorney General has used compensation funds to cover a portion of those funds between FY2002 – 2009. In FY2010, the line item was restored and $3,400,000 was appropriated. There are 31 programs that serve the entire state.

Iowa Department of Human Services

- *Continue joint training for child abuse protection staff and domestic violence advocates.* The IDHS continued to receive private funding to offer training and technical assistance to five communities working to improve their response to joint cases when domestic violence and child abuse coexist. When this funding ended in 2006, no further resources were identified to continue the effort.

Iowa Department of Justice

- *There should be a mechanism for homicide survivors in domestic abuse deaths to offer information to the Domestic Abuse Death Review Team in cases where there has been no prior community contact.* The death review team completed work on a survivor questionnaire and began using it in 2003. It has been distributed to local domestic violence programs, who are encouraged to offer survivors of domestic violence homicides the opportunity to offer information for the team.

Iowa Department of Public Health

- *There should be joint training between substance abuse and domestic violence service personnel.* The University of Northern Iowa sought federal funding to initiate the *Integrated Services Project* for substance abuse and domestic violence service personnel during 2002-2003. This project has continued under the administration of the Iowa Coalition Against Domestic Violence, and five Iowa communities have received the joint training.
- *Continue providing training and technical assistance for health care providers on identifying and responding to domestic violence*. IDPH has dedicated a .25 FTE to offer training for health care providers on domestic violence and sexual assault issues. During FY2007-2009, 11 training sessions were provided to a total of 287 healthcare providers; an additional 501 community professionals (law enforcement, judges, victim advocates, social service) also received training.

EXECUTIVE SUMMARY

The Iowa Domestic Abuse Death Review Team met a total of seven times during calendar years 2007 and 2008 to review domestic abuse deaths. The team reviewed a total of 33 cases, involving a total of 52 deaths.

The cases were identified by autopsy reports received by the Office of the State Medical Examiner and crime victim compensation applications received by the Iowa Department of Justice. Deaths included all homicides and suicides in Iowa that occurred within an intimate partner relationship. The team only reviewed those cases in which an initial criminal conviction had occurred or the outcome was a homicide/suicide. For this reason, the cases included in this report involve deaths that occurred as far back as 2004 and as recently as 2007.

Summary of Findings

Domestic abuse homicides in Iowa are largely crimes of gender violence, meaning that the predominant victims are female. In the cases reviewed for this report, 93.9 percent of the homicide perpetrators were men. Forty-two percent of the homicide perpetrators also took their own lives. In addition to the domestic violence victims and the two domestic violence perpetrators who were killed, another 10 people died – five children, three individuals who were new partners of the victim, and two others who were family members of the victim or the perpetrator.

In one-third of the cases, there was evidence the domestic violence victims had been trying to end the relationship with their perpetrators. The most common "precipitating" factor immediate to the homicide was threat of loss of the relationship, either from a decision made by the victim to end the relationship or the presence of a new intimate partner. National studies conclude that women are at greatest risk of homicide when they file for divorce, obtain a protection order or make other efforts to end the relationship. In 51 percent of the cases reviewed for this report, the couple had not been separated; in another 30 percent, the homicide occurred within the first month of separation.

The second most common factor immediate to the homicide was alcohol or drug use. The team noted that this factor was present in more of the cases than in prior years. Members believe that the use of substances prior to the homicide event in several cases contributed to the lethality of the domestic incident and that the deaths may not have occurred if either of the partners had not been under the influence. There is little evidence to indicate that domestic violence perpetrators are getting substance abuse assessment and treatment when needed.

The most common means of death was by firearm. Gunshot wound was the cause of death in 67.3 percent of all deaths. In addition, all of the perpetrator suicides were committed with a firearm. Shotguns were the most common firearm used. In only two of these cases was there a weapons seizure order in place at the time of the homicide.

There was documented evidence of prior domestic violence in less than half of the cases. The most commonly-occurring types of evidence found were prior threat of suicide or homicide by the perpetrator, prior calls to the police, and prior arrests for domestic abuse. Thirty-nine percent

of cases had prior calls to police for domestic assault; thirty percent had a history of prior arrests for domestic violence. Ten cases had a current order of protection in place at the time of the homicide; seven of them were between the domestic partners.

In contrast to cases reviewed in prior years, the team noted there were more cases where domestic violence victims had used community domestic violence services (6 cases). In addition, twelve domestic violence perpetrators had participated in a batterer's education program and ten of them had completed it. Clearly, these findings indicate that just seeking and providing services is not adequate to ensure safety – more is needed to hold batterers accountable for their abusive actions and enhance the effectiveness of intervention efforts.

Conclusions and Recommendations

The team concluded several key findings and recommendations:

- **The most dangerous time for domestic violence victims is when the victim is preparing to leave or has left the relationship.** Victims of domestic violence leaving a relationship are at 75 percent greater risk of being a victim of homicide that at any other time in their relationship. All homicide or suicide threats need to be taken seriously, especially when there is a history of domestic violence. Safety planning and better lethality assessment, within the context of a supportive community, is critical for victims in this situation.

- **Domestic violence, especially when accompanied with homicide or suicide threats and when firearms are available, are some of the highest risk cases in the criminal justice system.** Prosecutors should be very careful when pleading down these cases because of the risk to victims. Judges should hold protection order violators more accountable by ordering additional treatment for batterers if they are not responding to treatment that is routinely ordered. Persons convicted of misdemeanor domestic abuse should be required to surrender firearms upon conviction.

- **Iowa law offers public safety officials clear options for intervening in these cases and whenever there are threats of death, they should use whatever means are possible to ensure safety for potential victims.** Friends and family members of the victim should be encouraged to contact law enforcement or their county attorney's office when they are aware of these threats.

RECOMMENDATIONS

Recommendations to Communities – for the Prevention of Future Domestic Abuse Deaths

1. **Family, friends, and others** should take threats, including threats of homicide or suicide, seriously and should contact local law enforcement, clerk of court's office, or the local domestic violence program for help and information. The statewide domestic violence hotline number is 1-800-942-0333.
2. **Local media** should be familiar with guidelines for coverage of domestic violence cases, to use coverage as an opportunity to educate communities about risks and resources for help.
3. **Family law attorneys** should screen for domestic violence in *ALL* cases, make referrals to community resources knowledgeable in domestic violence, do lethality assessments and encourage use of protective orders as appropriate.
4. **Community professionals** who may come in contact with domestic abuse victims and perpetrators (such as health care providers, clerks of court, religious leaders, substance abuse counselors, mental health providers, social workers, and teachers) should be adequately trained to identify domestic abuse, appropriately intervene, and provide referral to resources knowledgeable about domestic violence in their community.
5. **Employers** should offer information on domestic violence and local resources to employees and supervisors, and should establish policies for safety in situations where an employee is in a dangerous relationship.
6. **Local domestic abuse programs** should continue to increase awareness and accessibility of services to under-served communities, enhance the cultural competency of staff, and collaborate with communities of color, working to develop leadership to address domestic abuse.

Recommendations to State Agencies – for Program and Regulatory Changes

Iowa Legislature

1. Make Iowa law compatible with federal law regarding firearm seizure requirements in all misdemeanor domestic violence convictions and those subject to an order of protection.
2. Increase funding of services to victims of domestic violence to adequate levels.
3. Give prosecutors the flexibility to speed up court proceedings if a case warrants it for safety reasons.
4. Provide resources (financial, training, and technical assistance) to communities to establish domestic abuse response teams. These multi-disciplinary teams are equipped to respond immediately to domestic abuse situations and enhance investigation, prosecution, and safety to victims and their children.

State Court Administrator

1. Judges and magistrates should use the most current set of uniform orders recommended by the Iowa Supreme Court, and not deviate from the language on the form.
2. Persons convicted of misdemeanor domestic abuse and subject to an order of protection should be *required* by the court to turn over firearms in their possession upon conviction. Relatives should not be allowed to store weapons and they should be turned over to law enforcement.

3. Place an order for batterer's education (BEP) immediately after the defendant is seen by the magistrate and charged. Use language such as "follow recommendations from the BEP for other services determined to be needed", so services can be individualized.
4. Place offenders ordered to BEP on formal probation; move quickly to hold them accountable when there is noncompliance.
5. Judges and magistrates should be adequately trained in the dynamics of domestic violence and treat cases as a higher priority of the court. When domestic violence is present in cases of divorce, they should:
    - refrain from ordering mediation as research has shown it is contraindicated and dangerous to the victim,
    - utilize neutral exchange sites, and
    - refrain from routinely awarding joint custody as allowed in *Iowa Code* 598.41.
6. With repeat offenders in substance abuse cases, order evaluation and treatment sooner.

Iowa Department of Corrections

1. Correctional officers should be trained to identify high-risk situations with clients who have a history of domestic abuse, and be able to recognize when the use of more aggressive monitoring and supervision practices may be indicated. Expand the use of jail-based BEP services.
2. Establish a "uniform" order for all BEP participants with substance abuse problems to receive a substance abuse evaluation and mandate treatment, if needed.
3. Maintain ongoing review and assessment of the effectiveness of batterer education programming and implementation of coordinated community responses to domestic violence.

Iowa Department of Education

1. Include dating violence and healthy relationships in the curricula for health education.
2. Ensure that schools implementing positive behavioral supports also provide domestic violence training to staff so they are aware of resources and supports for children who live in families with domestic violence.
3. Teachers, school nurses, and guidance counselors should be better equipped to respond to disclosures of domestic abuse besides just filing a child abuse report. They should offer referrals to local service programs and have a basic understanding of safety planning.

Iowa Department of Human Services

1. The department should work to ensure that child abuse protection staff has been trained in domestic violence they are able to identify the presence of domestic abuse and make appropriate interventions and referrals.
2. When clients with a history of domestic violence are identified, assess homicidal/suicidal potential by both parties to enhance service needs assessment and referral for safety planning.
3. Conduct child abuse investigations on families following domestic violence homicides. Always offer services in cases where a child has lost a parent to domestic violence or has witnessed serious abuse.

Iowa Department of Justice and county prosecutors

1. Prosecutors should vigorously pursue violations of protective orders and seek the maximum penalties.

2. County prosecutors should be encouraged to implement "evidence-based" prosecution policies in domestic abuse cases, even without the victim's testimony where other admissible evidence is available to convict (use of 911 tapes where hearsay exceptions and confrontation clauses allow, victim's statements to third parties, medical reports, thorough law enforcement investigative reports, etc.).

Iowa Department of Public Health

1. Continue support for cross-training between substance abuse and domestic violence programs at annual conferences and other training opportunities.
2. Promote the use of more jail-based treatment programs for substance abuse.
3. Provide training on strangulation and lethality risk to health care providers at annual conferences or other training opportunities.
4. Encourage hospitals to work with local law enforcement, prosecutors, and domestic violence agencies to have policies that allow sharing of confidential information when there is a credible threat of homicide/suicide. Recommend strategies for better documentation of assault injuries, including strangulation, to provide evidence needed for orders of protection.
5. Promote more prevention programming targeting young adolescents regarding dating behaviors and healthy relationships.

Iowa Department of Public Safety and local law enforcement agencies

1. In every domestic abuse case seen by law enforcement, domestic violence service information and referral should be given to victims. As stated in *Iowa Code* 236.1 the information should be provided immediately whenever an arrest is made. When possible, contact with the victim by a domestic violence advocate should occur at the time of the arrest, in collaboration with the law enforcement agency.
2. Law enforcement officials should enforce federal law and seize firearms from persons convicted of domestic abuse. Relatives should not be allowed to hold onto weapons in these cases.
3. Stalking behavior and history of strangulation needs to be better recognized and documented in domestic abuse cases by local law enforcement agencies. This will allow escalating abuse and dangerousness to be more fully identified so proper intervention can take place.
4. Every five years, all law enforcement officers in Iowa should receive a minimum of four hours training on domestic abuse and stalking in consultation with the Iowa Coalition Against Domestic Violence.

Iowa Law Enforcement Academy

1. Every 5 years, all law enforcement officers in Iowa should receive a minimum of 4 hours training on domestic abuse and stalking in consultation with the Iowa Coalition Against Domestic Violence.

Office of the State Medical Examiner

1. Offer training on recognizing and documenting injuries and presence of strangulation as risk factors for domestic violence homicide. Collaborate with state trainers in law enforcement, prosecution, public health and domestic violence services to provide this type of training for emergency health care personnel and other community professionals.

FINDINGS

The Iowa Domestic Abuse Death Review Team met seven times between January 2007 to December 2008, to review domestic violence related deaths that had occurred in prior years. Unlike the Child Death Review Team, this team reviews cases only after an initial criminal disposition has been determined. This allows access to more case information for a more thorough review. In this two year period, the team reviewed a total of 33 cases from deaths that occurred between 2004 and 2007. As mentioned previously, they do not reflect all of the domestic violence related deaths occurring in that calendar year, just the number of deaths reviewed by the team during the calendar years 2007-2008.

The number of deaths by manner of death is listed in Table 1.

Table 1. Manner of domestic abuse deaths by gender

	Female	Male	Total
Homicides	28	9	**37**
Suicides	1	14	**15**
Total	**29**	**23**	**52**

Fifty-two people died as a result of domestic violence in the 33 cases that were reviewed and analyzed by the team during the two-year period. Thirty-seven deaths were homicides, and 15 were suicides. Forty-two percent of the homicide perpetrators took their own lives; two of the suicides did not involve a homicide. Two female victims of domestic violence killed their abusers; the remaining male homicides were either children or new partners of the female domestic violence victim.

Homicide victims were classified in relation to the domestic violence. (Table 2).

Table 2. Relationship of homicide victim to the domestic violence*

The homicide victim was also…	# of deaths
The victim of the domestic violence	**24**
The perpetrator of the domestic violence	**2**
Both a victim & a perpetrator of DV	**1**
A new partner of the DV victim	**3**
A child of the DV victim & perpetrator	**5**
Another family member of the DV victim or perpetrator	**2**
Total	**37**

*Excludes perpetrator suicides

Sixty-five percent of the homicide victims were the victim of the domestic violence. Two perpetrators of domestic violence were killed by their partner. One of the cases involved partners who were both perpetrators and victims of the domestic violence; the team could not identify a primary aggressor in the case. Just over one-fourth of the people killed in the fatal incidents were other relationships, such as a child, new partner of the domestic violence victim, or another family member.

Demographic Information – All Deaths

Gender of those who died was included in Table 1 on the previous page. Ages are presented in Table 3 below.

Table 3. Age of all decedents by type of death

	0-17	18-25	26-35	36-45	46-55	56-65	> 65	Total
Homicide	5	3	10	12	5	1	1	**37**
Suicide	0	1	3	7	3	0	1	**15**
Total	**5**	**4**	**13**	**19**	**8**	**1**	**2**	**52**

Almost two-thirds of the deaths occurred to those between the ages of 26 and 45. There were five children under the age of 18 killed in domestic homicides, and two people over the age of 65 who died as a result of domestic violence.

The race or ethnicity of those who died is presented in Table 4.

Table 4. Race/ethnicity of decedents by type of death

	Caucasian	African/Am.	Hispanic	SE Asian	Native Am.
Homicide	30	2	5	0	0
Suicide	15	0	0	0	0
Total	**45**	**2**	**5**	**0**	**0**

The vast majority (86.5%) of decedents were Caucasian. Those who died by suicide were all Caucasian.

Information on the population area distribution of the location in which the death occurred is contained in Table 5.

Table 5. Population area of county of death

	Total
Rural (< 10,000)	**2**
10,000 – 20,000	**6**
> 20,000	**22**
Urban (MSA* counties)	**22**

* Metropolitan Statistical Area

Forty-four percent of the deaths occurred in the largest/urban areas of the state. Only 15% occurred in counties with a population of less than 20,000.

Cause and Manner of Deaths

Information on cause of death is included in Table 6, on the next page.

Table 6. Cause of Death

	Total
Gunshot wound	**35**
Traumatic stab wound	**7**
Beating/blunt force trauma	**4**
Asphyxia (suffocation)	**3**
Other causes	**3**
Total	**52**

More than two-thirds of the deaths (67.3%) were caused by gunshot wound(s). Only 13 percent were fatal stab wounds, and the remaining causes were blunt force trauma, suffocation or other causes (included fire and multiple causes).

The primary weapon that was used to commit the homicide is listed in Table 7.

Table 7. Weapon used in death

	Total
Firearm	**35**
Shotgun (7)	
Handgun (4)	
22 Caliber rifle (3)	
22 Caliber handgun (2)	
Other/not specified (19)	
Knife	**7**
Other	**4**
Hands/manual	**3**
Multiple weapons	**3**

Firearms were used in 67.3 percent of the deaths. Of firearms that were specified, shotguns were the most common, followed by handguns. In the one case that could be tracked, the firearm was acquired the month before the homicide/suicide. None of the perpetrators were under any current order to surrender weapons at the time the death(s) occurred, which is contrary to requirements for any felony convictions that may have existed.

Information on the location of the death is included in Table 8.

Table 8. Location of death

	Total
Joint residence	**27**
DV victim residence	**7**
DV perpetrator residence	**6**
Outdoors/public area	**5**
Worksite	**2**
Other/unspecified	**3**

Three-fourths of the deaths occurred in a residence – either at the joint residence of the couple or at the domestic violence victim's or perpetrator's home. Half of all deaths (51.9%) were at the joint residence of the couple (in cases where they had not separated). In 9.6 percent of cases, the deaths occurred (or the body was found) in an outdoor, public location. Two homicides were committed in or near the victim's worksite.

Domestic violence relationship analysis

The following sections provide information specific to the domestic relationship between the parties, and to the domestic violence that occurred. The team analyzed both demographic and other circumstantial factors in an attempt to understand more about the relationship between the two parties and the circumstances leading up to the homicide/suicide in the 33 cases reviewed during 2007-2008. In some cases, one of the parties may still be living, either because the perpetrator did not commit suicide and was convicted, it was a suicide only, or the murder attempt may have failed. The demographic data is portrayed in an attempt to provide a profile of gender, age, racial/cultural, educational, or occupational factors that may be specific to domestic abuse deaths.

Demographic Information – Partners in the domestic relationship

Gender, age, racial/ethnic background, educational background, and occupation of the individuals who were identified as the victim of the domestic violence and the perpetrator are presented in Tables 9 – 14.

Table 9. Gender of partners in the domestic relationship

	Female	Male
Victim of the domestic violence	32	0
Perpetrator of the domestic violence	0	32
Both a victim and a perpetrator of DV	1	1

All relationships were heterosexual partners. In 96.9 percent of cases, the primary victim of the domestic violence was female and the perpetrator was male. There was one case in which the team determined that the domestic violence was "mutual", in that there was not a primary aggressor in the relationship.

Table 10. Age of primary domestic violence victim and perpetrator

	18-25	26-35	36-45	46-55	56-65	> 65	Total
Victim of the domestic violence	3	11	12	5	0	1	**32**
Perpetrator of the domestic violence	2	4	18	7	0	1	**32**
Both a victim and a perpetrator	0	2	0	0	0	0	**2**
Total	**5**	**17**	**30**	**12**	**0**	**2**	**66**

The majority (71.9%) of domestic violence victims involved in these cases were between the ages of 26-45. The majority of perpetrators (56.2%) were in the age range of 36-45 years. Team members also compared the differences in age between the victims and perpetrators. See Table 11.

Table 11. Age differences between domestic violence victim and perpetrator

	< 3 years	3 – 5 years	5 – 10 years	>10 years	Total
# of cases	13	6	8	6	**33**

57.6 percent of cases had less than 5 years difference in ages; in one-fourth (24%) of cases, there was a 5-10 year age difference and in less than one-fifth (18.2%), the age difference was greater than 10 years.

Table 12. Race/ethnicity of domestic violence victim and perpetrator

	Caucasian	African Amer.	Hispanic	SE Asian	Native Am.
Victim of the domestic violence	27	4	2	0	0
Perpetrator of the domestic violence	20	8	3	0	0
Both a victim & a perpetrator of DV	2	0	0	0	0
Total	**49**	**12**	**5**	**0**	**0**

The majority (74.2%) of domestic violence victims and perpetrators were Caucasian. In 84.8 percent of the cases, the primary victim/perpetrator had the same racial/ethnic background.

Table 13. Educational background of domestic violence victim and perpetrator

	< 8th grade	9 – 12 grade	HS Diploma	Some College	BA/ BS	>BA/ BS	Not known
Victim of the domestic violence	0	6	13	3	4	0	6
Perpetrator of the domestic violence	1	4	15	4	2	0	6
Both a victim & a perpetrator of DV	0	0	0	1	1	0	0
Total	**1**	**10**	**28**	**8**	**7**	**0**	**12**

Note: Information not available in all cases.

In the cases where educational background was known, it appeared to be distributed across all levels. In half (51.9%) of these cases, the partners had a high school diploma. In 20.3 percent of known cases, the victim or perpetrator had less than a high school education' in 27.8 percent they had some college or more. In almost half (45%) of the cases where education levels were known, the victim and perpetrator had attained the same level of education. Forty percent of the victims had a higher education level than the perpetrators; 15% of the perpetrators had a higher education level than their victims. None of the domestic violence victims and perpetrators in these cases had a post-graduate education.

Table 14. Occupation of primary victim/perpetrator

	Unemp/ None	Home-maker	Construc/ Manuf.	Service	Self-employed	Prof/ Technical	Not known
Victim of the DV	2	3	7	5	1	8	6
Perpetrator of the DV	4	0	13	4	1	6	4
Both a victim & perpetrator of the DV	1	1	0	0	0	0	0
Total	**7**	**4**	**20**	**9**	**2**	**14**	**10**

Only 12.5 percent of the known occupational histories included individuals who were unemployed or unable to work. The majority of individuals were working in the fields of construction/manufacturing (35.7%) or in a professional/technical field (25.0%).

Circumstances Related to the Fatalities

During case reviews, team members document the presence of factors that occur just prior to the homicide or suicides. These are often identified through the police investigation reports, including interviews with surviving family and friends, or in other court records. However, this information may be incomplete if certain documents are not received on a case or if a complete investigation is not conducted (such as in the cases of homicide/suicide). Table 15 includes the factors that team members were able to identify as being present within a few hours to a few days prior to the homicide or suicide. These factors are not mutually exclusive, and several may be present for each death. The totals reflect the number of cases in which these factors were determined to be present.

Table 15. Factors identified prior to the fatalities

	Total Cases
Divorce/threat of divorce or victim was trying to end the relationship	18
Alcohol/drug use by the homicide perpetrator	17
Prior threat of homicide and/or suicide	16
Access to firearms by the homicide perpetrator	13
Partner was excessively jealous/controlling	12
Financial problems/recent unemployment	11
High conflict was present in the relationship	8
Probation or other legal violations	6
Mental health problem	6
Partner discovered the new dating partner	5
Victim was isolated with little support	5
Sexual coercion/assault	5
Custody conflict	5

In more than half (54.5%) of the cases, there was a recent threat of divorce or the victim was trying to end the relationship with the domestic violence perpetrator. Alcohol or drug use was also was a factor immediate to the homicide/suicide in more than half (51.5%) of the cases. There was a previous threat of homicide or suicide in almost half (48.5%) of the cases. Financial problems appeared to be a precipitating factor in one-third (33.3%) of the cases.

Prior year data and other national studies support the finding that women are most at risk when they choose to separate from an abusive partner. In Table 16, the length of the relationship is summarized and in Table 17, the length of separation between the separation and the domestic violence fatality is presented.

Table 16. Length of relationship between the domestic violence victim and perpetrator

	Total
Less than 1 year	**2**
1 – 3 years	**9**
3 – less than 5 years	**6**
5 – less than 10 years	**4**
10 or more years	**10**
Unknown	**2**

In 45.2 percent of the cases in which it was known, the relationship was more than five years old. However, there was no clear pattern that appeared regarding length of time the partners had been in a relationship.

Table 17. Length of separation between the domestic violence victim and perpetrator

	Total
Not separated	**16**
Separated less than 1 week	**8**
Separated 1 week to 1 month	**2**
Separated 2 – 3 months	**1**
Separated 4 – 6 months	**2**
Separated 7 – 12 months	**2**
Separated more than 1 year	**2**

In almost half (48.5%) of the cases, there was not a separation between the partners. (There may have been evidence, however, of a recent threat of separation – refer to Table 15.) In almost one-third (30.3 %) of the cases, the separation had occurred within the past month. Both a recent separation and/or perceived threats to the relationship ending are the highest risk factors for domestic violence homicide or suicide. **This is when the victim asserts her desire for safety, which is often viewed by the perpetrator as a threat to his control.** In the cases where the separation occurred over a year before the deaths, there had been either jealousy over a new dating partner or custody conflict around the time of the homicide.

Table 18 describes the number of cases where children were present at the scene of the homicide or suicide.

Table 18. Child witnesses to the death(s)

	Total
Children present at scene	**10**
# of children killed	5
# surviving loss of parent/s	5

Five of the 10 children present survived the death of one or more parents. In addition, there were other minor children of one or both parents who were not present but lost a parent(s). Studies on the effects of witnessing domestic violence reveal that children who live in homes where domestic violence is present face future emotional, developmental, and social disruptions. These challenges are multiplied if the child witnesses a parent being murdered.

Requirements under 135.110 (2)

Enabling legislation requires the team to "...review the relationship between the decedent victim and the alleged perpetrator from the point where the abuse allegedly began, until the domestic abuse death occurred...". Team members attempt to gain this information from law enforcement and other court records. However, if there is no prior contact with a law enforcement agency, it can only be obtained from interviews with surviving family members. Another approach the team has taken in reviewing cases is to identify those circumstances in which one or both domestic partners may have had contact with a community agency prior to the fatality.

Table 18 lists the type of information identified as evidence that there was prior domestic violence. (Information is not mutually exclusive, since several factors may be present in any one case.)

Table 18. Evidence of prior domestic violence

	# of Cases
Prior suicide threat	**16**
Prior police calls	**13**
Prior homicide threat	**11**
Prior domestic abuse arrests	**10**
Known history of domestic violence (as reported by friends/family)	**9**
Prior contact with DV services/shelter	**6**
Prior injury	**5**

The most common form of evidence documented was a suicide threat regarding the relationship ending. In more than one-third (39.4%) of cases, there had been prior police calls for domestic violence. Prior arrests for domestic violence occurred in 30.3 percent of the cases. A known history of domestic violence, as reported by friends or family, was documented in law enforcement reports only 27.2 percent of the time.

Contact with a domestic violence shelter or service program was confirmed in six of the cases, although this information is difficult to obtain if victims seek services in a community other than their own. There was little evidence of prior injury noted from the autopsies, and medical records of the victims could not be obtained if it was not known where they may have sought care.

Team members looked for evidence of prior community contact in an attempt to understand if there were opportunities for intervention when there was a known history of domestic violence. This information is not always documented in records, so team members identified cases where the victim or perpetrator may have been involved with a community agency. Refer to Table 19, noting that some of this information was also included in Table 18.

Table 19. Prior community contact in cases with a known history of domestic violence

	# of cases
Prior police calls	**13**
Prior domestic arrests	**10**
Prior batterer's education program involvement	**12**
Prior court involvement – DV charge pled down	**6**
Prior DV service/shelter contact	**6**
Prior child abuse investigation	**6**
Custody proceedings	**5**
Prior hospital contact	**5**

In up to 39.3 percent of cases, the couple had been known to local law enforcement due to prior calls to the home. More than one-third (36.3%) of these cases involved a perpetrator who had attended a batterer's education program. Other types of contact that the couple had in the community were with protective services personnel, family law attorneys, and health care services. Even if the issue that was the primary reason for community contact was not the domestic abuse – professionals in all of these community services have opportunity to screen and refer for domestic violence, or to assess danger levels.

Information on the presence of stalking is illustrated in Table 20. It includes information on cases where there were current orders of protection in place at the time of the fatality, or if there had been previous orders filed in the case. The team tracks information about who filed the order of protection and if it was against the domestic partner or another individual.

Table 20. Evidence of stalking prior to homicide

		Total
Order of protection (current)		**10**
Sought by DV victim against current partner	4	
Sought against DV victim by current partner	3	
Sought by either party against another/unknown	3	
Order of protection (previous or expired)		**16**
Sought by DV victim against a previous partner	6	
Sought against DV victim by a previous partner	7	
Sought by either party against another individual	3	
Other documentation of stalking by law enforcement		**6**

Law enforcement experts on the team believe that stalking is a behavior that is usually present in domestic violence cases but is often not well recognized by law enforcement agencies. Six of the 33 cases had documentation in the law enforcement records of prior stalking behavior. The presence of an order of protection (under Chapters 236, 598, or 811 of the *Iowa Code*) is considered evidence of stalking. There were ten orders of protection involving eight of the cases that were current at the time of the homicide/suicide. In only three of these cases, the protection orders were in force by both parties against the other. There had been a total of 16 previous orders of protection filed in 12 of the cases; these were expired at the time of the fatality.

Clearly, safety planning and other lethal risk assessment are important opportunities for intervention at the time that a protection order is filed.

Homicide Perpetrator Outcome & History

This section describes the outcome of the criminal charges against the homicide perpetrator and criminal history of all domestic violence perpetrators. Table 21 includes the criminal outcome for perpetrator that did not die by suicide.

Table 21. Homicide Perpetrator Outcome (18 cases)

	Total
Convicted of Murder 1	**10**
Convicted of Murder 2	**5**
Convicted of Manslaughter	**1**
Convicted of Vehicular Homicide	**1**
Perpetrator has not been apprehended	**1**

There were criminal convictions in all of these cases, except for one in which the perpetrator has not been apprehended (missing since 2001). The majority of perpetrators (55.6%) were found guilty of murder in the first degree.

The team routinely requests criminal histories on all domestic violence victims and perpetrators involved in the fatalities. Arrest histories for all perpetrators are listed in Table 22. (This information may be duplicative in cases where one perpetrator had prior arrests for more than one crime.)

Table 22. Perpetrator arrest history (all 33 cases)

		Total
No previous arrests documented		**13**
Previous arrest history		**20**
Alcohol/drug related	17	
Domestic abuse	14	
Assault	4	
Prior incarceration		**15**
On probation/parole (at time of homicide)		**8**
Weapons seizure order		**2**

There was a history of arrest in 60.6 percent of the cases. Over half of the prior arrests were for alcohol or drug related crimes. Forty-two percent were prior domestic abuse arrests. Fifteen of the perpetrators had prior incarcerations, although the specific crimes were not noted. Eight of the perpetrators (24.2%) were on probation or parole at the time the fatality occurred. In spite of the fact that persons convicted of felony domestic assault are required to surrender firearms, there was evidence of only two cases in which a weapons seizure had been ordered by the court.

Team members noted other information on perpetrator history where there was previous contact with community agencies that might have been a point of intervention or lethality assessment. This information is incomplete for all cases, as it is dependent upon the documentation received by the team. Table 23 summarizes these findings.

Table 23. Perpetrator history of contact with other community agencies

		Total
History of substance abuse		**18**
Prior substance abuse treatment	8	
Prior batterer's education program involvement		**12**
With successful discharge	10	
Did not complete treatment	2	
Prior mental health treatment		**6**
Prior founded child abuse		**6**

Although a history of substance abuse was present in more than half (54.5 %) of the cases, there was documented history of substance abuse treatment in only one-fourth (24.2%) of them. Twelve perpetrators had been ordered to batterer's education treatment; further review of corrections records revealed that ten had been successfully discharged and two had not completed the program. Mental health treatment and contact with the child abuse protection system were other community contacts where there might have been an opportunity for intervention.

Victim History

Criminal history and contact with community agencies were also documented for victims of the domestic violence, when it was available. This information is incomplete for all cases, as it is dependent upon the documentation received by the team. Table 24 summarizes these findings.

Table 24. Victim history

		Total
Previous arrest history		**10**
Alcohol/drug related	5	
Domestic abuse	1	
Prior contact with DV services or shelter		**6**
History of substance abuse		**6**
Prior founded child abuse		**3**
History of suicide threat/attempts		**1**

Ten (30.3%) of the domestic violence victims had a criminal arrest history. The majority of the arrests were for substance abuse, and there was a documentation of substance abuse problems in six of the cases. As noted previously, less than one-fifth (18.2%) of the cases involved prior contact with community domestic violence services. Evidence of a previous suicide attempt or threat was found in one case. Three cases involved a prior confirmed child abuse by protective services personnel against the domestic violence victim. Similar to the cases involving prior community contact by the homicide perpetrator, these contacts might have offered a community professional an opportunity to intervene with safety planning or other lethality assessment.

Further information about the Iowa Domestic Abuse Death Review Team may be obtained by writing or calling. The contact information is as follows:

Domestic Abuse Death Review Team
Lucas State Office Building, 6th Floor
321 East 12th St.
Des Moines, Iowa 50319-0075
515/281-5032
http://www.idph.state.ia.us/bh/domestic_abuse_review.asp