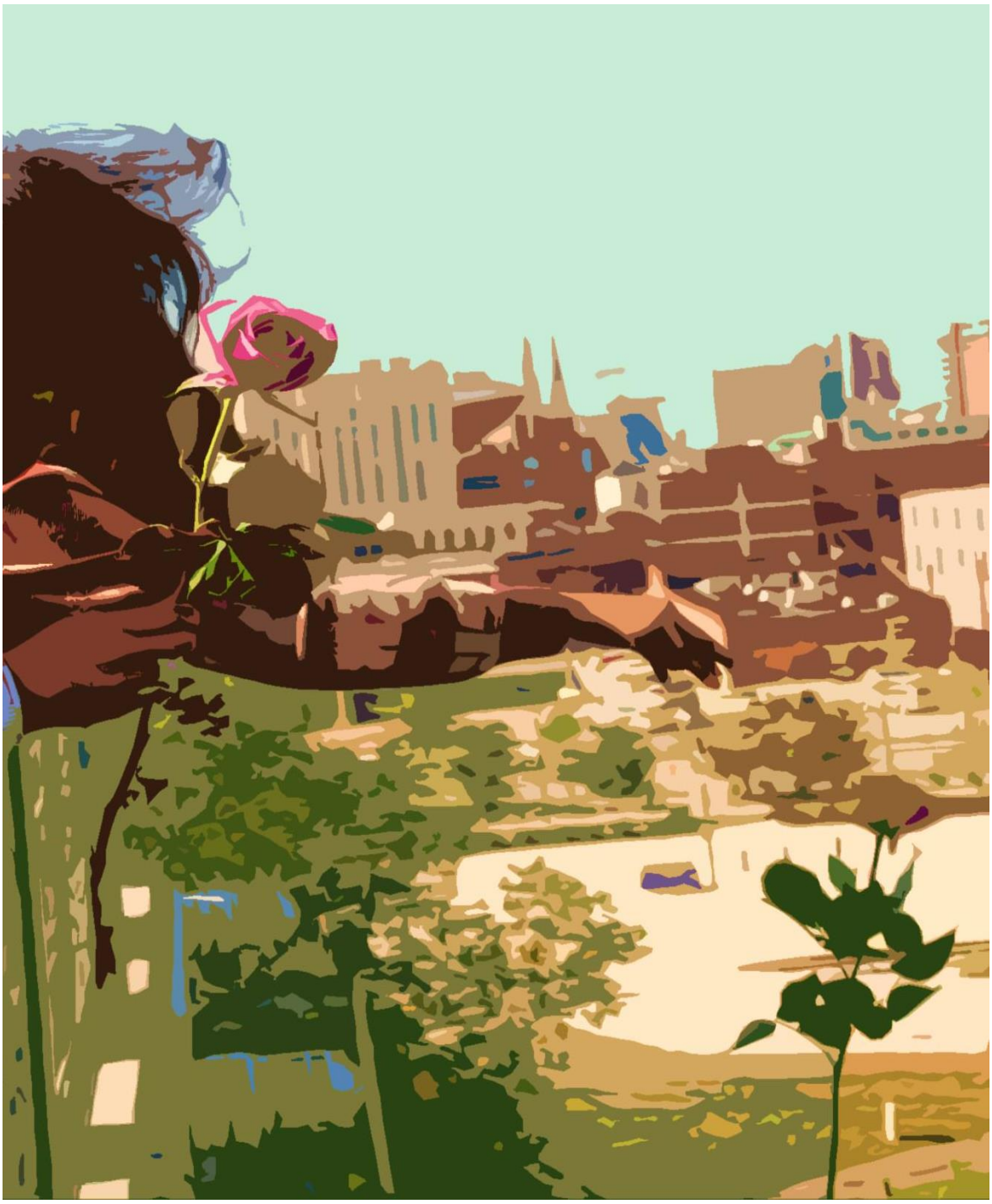

DOMESTIC VIOLENCE HOMICIDE IN NASHVILLE

DOMESTIC ABUSE DEATH REVIEW TEAM NASHVILLE-DAVIDSON COUNTY, TN

2016 ANNUAL REPORT

<u>Cover Photo</u>: photo used with permission from the Nashville Coalition Against Domestic Violence (NCADV) Annual "Meet Us At The Bridge" event where a rose is thrown from the John Seigenthaler Pedestrian Bridge into the Cumberland River to honor each victim of domestic violence homicide.

This project was supported by Grant No. 2015-WE-AX-0020 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author (s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

Metro Office of Family Safety

DOMESTIC ABUSE DEATH REVIEW TEAM
NASHVILLE – DAVIDSON COUNTY, TN
2016 ANNUAL REPORT

PREPARED BY:

Diane Lance, Department Head

Becky Owens Bullard, High Risk Programs Manager

Metropolitan Government of Nashville-Davidson County, Office of Family Safety

PREPARED FOR:

Metropolitan Government of Nashville-Davidson County, Mayor's Office

The Honorable Mayor Megan Barry

&

Metropolitan Government Office of Family Safety Advisory Committee

DEDICATED TO:

Victims and survivors of domestic violence in Nashville-Davidson County

Published November 2017

ACKNOWLEDGEMENTS

The Nashville Domestic Abuse Death Review Team (DADRT or Team) would like to thank Mayor Megan Barry for her support of the Team's activities to examine domestic violence fatalities. The Team would also like to express its gratitude to the Metro Government of Nashville-Davidson County Office of Family Safety (OFS) Advisory Committee for its guidance and support of the Office of Family Safety. Members of the OFS Advisory Committee include: the Nashville Chief of Police, the District Attorney General of Nashville-Davidson County, the Director of the Metropolitan Department of Law, the Davidson County Sheriff, a Domestic Violence specialized Circuit Court Judge or Special Master, a Domestic Violence specialized General Sessions Court Judge, a Domestic Violence specialized Juvenile Court Judge, a representative of the Mayor's Office, the Director of Criminal Justice Planning, the Director of Finance, the Department Head of the Office of Family Safety, and the Director of Metro's Jean Crowe Advocacy Center.

We are extremely grateful for our Team members who dedicated time out of their busy schedules to thoughtfully review the selected 2016 case and assist the Office of Family Safety in formalizing DADRT's policies and procedures. The dedication and expertise DADRT members bring to each meeting is invaluable to identifying the gaps in domestic violence homicide prevention and response in Nashville-Davidson County.

Lastly, we would like to express our sincere gratitude to all individuals that volunteered their time to provide insight as to why this homicide occurred. We are especially grateful to those family and friends who suffered a painful loss but were willing to share with us in order to lead our community to a better understanding of how to address domestic violence and how to attempt to prevent such terrible tragedies.

It is the hope of our Team that this report will lead to a better understanding of domestic violence in our community, the strengths and weaknesses in our response systems, and the steps that we must take to improve victim safety and offender accountability.

Dear Mayor Barry,

The Nashville-Davidson County Domestic Abuse Death Review Team (DADRT) would like to share with you our 2016 annual report.

During 2016, the Team reviewed one case of intimate partner homicide. This homicide involved multiple contacts with both the criminal justice system and community non-profit organizations before the homicide. It also involved an extensive history of abuse for the victim and of abusive behavior for the suspect.

The Office of Family Safety's High Risk Programs Manager officially began coordinating the Team's activities in 2016, which led to formalized case review policies and procedures as well as the creation of multiple data collection tools. These policies and procedures were adapted from training by the National Domestic Violence Fatality Review Initiative and their best practices recommendations.

The most significant procedural change in 2016 was the shift from examining every domestic violence homicide that occurred in Nashville-Davidson County to limiting reviews to one or two lethal or near lethal cases per year. This in-depth case review allows the team to investigate interactions with the victim and suspect in more detail and to interview family and friends of involved parties for a more profound understanding of the fatality.

It is the Team's hope that this report and the case review included within it will allow us to address the gaps in our response and prevention of domestic violence in order to reduce domestic violence homicide in our community and make Nashville the safest city for women and children.

If you have any questions about the report, please contact Becky Bullard (615-862-5158 or beckybullard@jis.nashville.org), the High Risk Programs Manager at the Metropolitan Government of Nashville-Davidson County Office of Family Safety.

Sincerely,

Diane Lance

Diane Lance
Department Head
Office of Family Safety

Bonnie Beneke

Bonnie Beneke
DADRT Chair
Tennessee Dept. of Children's Services

Michelle Richter

Captain Michelle Richter
DADRT Sub-Chair
Metro Nashville Police Dept.
Domestic Violence Division

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ACRONYMS & ABBREVIATIONS

ACEs	Adverse Childhood Experiences
AMC	Anger Management Class
AWAKE	Advocates for Women and Kids' Equality
BIP	Batterers' Intervention Program
CLA	Civil Legal Advocacy (Program)
DA	District Attorney
DADRT	Domestic Abuse Death Review Team
DEC	Drug Endangered Children
DV	Domestic Violence
DVD	Domestic Violence Division (of the Metro Nashville Police Department)
EIM	Early Intervention Meetings
FJC	Family Justice Center
GS Court	General Sessions Court
HRIP	High Risk Intervention Panel
HWC	Handle With Care
IPV	Intimate Partner Violence
JCAC	Jean Crowe Advocacy Center
LAP	Lethality Assessment Program
AMEND	AMEND Together
MNPD	Metro Nashville Police Department
MNPS	Metro Nashville Public Schools
OFS	Office of Family Safety (of Metro Nashville Government)
OP	Order of Protection
SAC	Sexual Assault Center
VWC	Victim Witness Coordinator
YHTP	You Have The Power
YWCA	YWCA Nashville & Middle Tennessee

EXECUTIVE SUMMARY

The Domestic Abuse Death Review Team or DADRT is an interagency team that has met informally since 1995 and was officially created by Executive Order in 2002. The purpose of the Team is to review annually one to two domestic violence homicides that occurred in Nashville and develop recommendations to improve domestic violence prevention and response from the findings of that review.

In 2016, the case selected for review was a strangulation of a woman by her boyfriend. The Team compiled information about this case from criminal justice records, participating agencies, and an interview with a family member of the victim. From this information, the Team detailed several findings and recommendations on how to improve prevention and response to domestic violence in Nashville.

The interview with the victim's family member painted a family history of emotional and physical abuse as well as substance abuse. There were several instances where interventions at a young age could have assisted the victim, particularly after potentially witnessing her father's suicide. Therefore, many of the Team's recommendations center on early childhood prevention.

Additionally, the victim had multiple interactions with the criminal justice system and domestic violence non-profits in adulthood as a result of abuse from her estranged husband. However, the victim had minimal participation in criminal justice proceedings and did not follow through with services. High risk screening tools could have assisted police, prosecutors, and advocates to identify the victim as at risk for homicide.

The Team also found that the perpetrator was involved in the criminal justice system from a young age and abused several women with minimal consequences and escalating violence. Enhanced accountability for domestic violence crimes could have communicated the seriousness of prosecution to the perpetrator.

Finally, both the victim and the perpetrator had experienced or perpetrated significant violence with previous partners. Team members believe that the normalization of violence in these prior relationships contributed to the rapid escalation to deadly violence in this case. The Team will continue to explore this troubling dynamic we have designated a "relational risk transfer."

Additional lethality indicators found by the Team include:[1]

For the Victim from Previous Intimate Partners:

- Assaulted while Pregnant
- Strangled
- Escalating Victimization

For the Perpetrator from Previous Intimate Partners:

- Multiple Strangulations
- Use of and Access to a Firearm
- Escalating use of Violence

**The lethality indicators between the victim and the suspect are unknown due to the lack of information surrounding their brief relationship.

[1] These indicators are taken from a research study by Jacquelyn Campbell in 2003 that identified several factors common in fatal and near fatal intimate partner violence. Campbell, Jacquelyn et al. "Risk Factors for Femicide in Abusive Relationships: Results From a Multisite Case Control Study." *American Journal of Public Health* 93.7 (2003). July 2003. Web. 16 Mar. 2017."

The key findings and subsequent recommendations from the review include:

- *The victim experienced traumatic events as a child.*
  - Recommendation: Identify children who have experienced trauma and address it through programs such as Handle With Care (HWC), increased school therapy access, Adverse Childhood Experiences (ACEs) identification, & increased community counseling resources.
  - Recommendation: Increase early positive role modeling and healthy relationships education through programs in elementary, middle, and high schools, such as YWCA AMEND Together & Girls Inc.; You Have The Power (YHTP) Healthy Relationships & Bullying; Sexual Assault Center (SAC) Safe@Last & Be.; and Advocates for Women and Kids Equality (AWAKE) Healthy Relationships & Truancy Intervention.

- *Substances were abused by the victim's mother & by both the victim & perpetrator.*
  - Recommendation: Increase awareness of the impact of substance abuse on domestic violence cases through improved training, community awareness of drug endangered children, and increased availability of specialized treatment programs for victims.

- *The victim did not follow through with services and participated minimally in prosecution.*
  - Recommendations: Create additional avenues for outreach and support for victims that are reluctant to follow through with services and prosecution by increasing interagency coordination through programs established since the homicide, including: the Lethality Assessment Program (LAP), the High Risk Intervention Panel (HRIP), the District Attorney's Office Early Intervention Meetings (EIM), the Civil Legal Advocacy (CLA) Program, the Jean Crowe Advocacy Center (JCAC), and the forthcoming Family Justice Center.

- *The perpetrator was arrested multiple times for domestic violence crimes against multiple victims and served minimal time in jail.*
  - Recommendations: Enhance criminal justice system response to intimate partner violence cases through intimate partner violence–specific dockets, decreased turn-around time from incident to court resolution, enhanced sentencing for subsequent domestic violence convictions, a clearer and more effective firearms dispossession process for domestic violence offenders, and continued High Risk Intervention Panel (HRIP) case review to hold high risk offenders accountable.

- *The victim and perpetrator had multiple high risk indicators and their previous abusive relationships may have normalized high levels of violence and rapidly escalated the violence in their brief relationship.*
  - Recommendations: Continue to utilize and enhance Metro Nashville's Lethality Assessment Program (LAP) screen and High Risk Intervention Panel (HRIP), both established since the time of this homicide, to identify and respond to high risk cases; increase high risk offender identification through probation officer screening and high risk victim identification through victim service provider screening; and research "relational risk transfer" and its impact on lethality.

PARTICIPATING DOMESTIC ABUSE DEATH REVIEW (DADRT) MEMBERS & ADDITIONAL COMMUNITY MEMBERS FOR THE 2016 CASE REVIEW

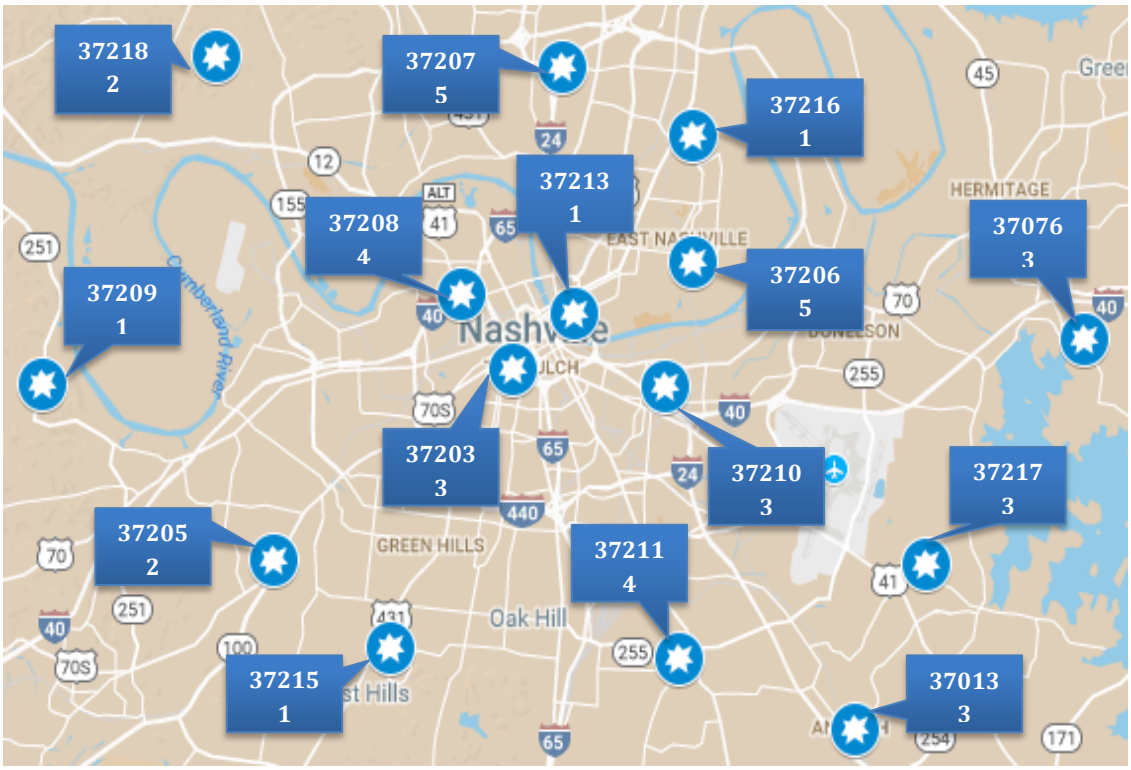
James (Jim) McDowell	Davidson County Sheriff's Office
Susan Tucker-Smith	District Attorney's Office Victim Witness
Ana Escobar	District Attorney's Office
Kimi DeMent	Legal Aid Society of Middle Tennessee and the Cumberlands
Allison Cooley	Legal Aid Society of Middle Tennessee and the Cumberlands
Nichelle Foster	Metro Public Health Department
Captain Michelle Richter	Metro Police Domestic Violence Division
Lieutenant Tommy Widener	Metro Police Domestic Violence Division
Sergeant Ralph Griggers	Metro Police Domestic Violence Division
Diane Lance	Office of Family Safety
Becky Bullard	Office of Family Safety
Whitney Blanton	Office of Family Safety – Jean Crowe Advocacy Center
Peter Macdonald	Private Citizen
Susan Kay	Private Citizen
Bonnie Beneke	Tennessee Department of Children Services
Dr. Melanie Lutenbacher	Vanderbilt School of Nursing
Cathy Gurley	You Have the Power
Tracy DeTomasi	YWCA Nashville & Middle Tennessee
Amy Dunning	YWCA Nashville & Middle Tennessee (currently with Martha O'Bryan Center)
Allison Cantway	YWCA Nashville & Middle Tennessee

2012-2016 Domestic Violence Fatality Statistics for Nashville-Davidson County

Domestic violence homicides in Nashville, TN have varied in frequency over the past five years, between 2012 and 2016. According to Tennessee's domestic violence statute, domestic violence homicide includes fatalities perpetrated by intimate partners as well as by non-intimate partners. An intimate partner includes current or former spouses, current or former dating partners, and individuals who have children in common. Non-intimate partner domestic violence perpetrators include family members as well as individuals that live together without intimate or familial relationships, such as roommates.

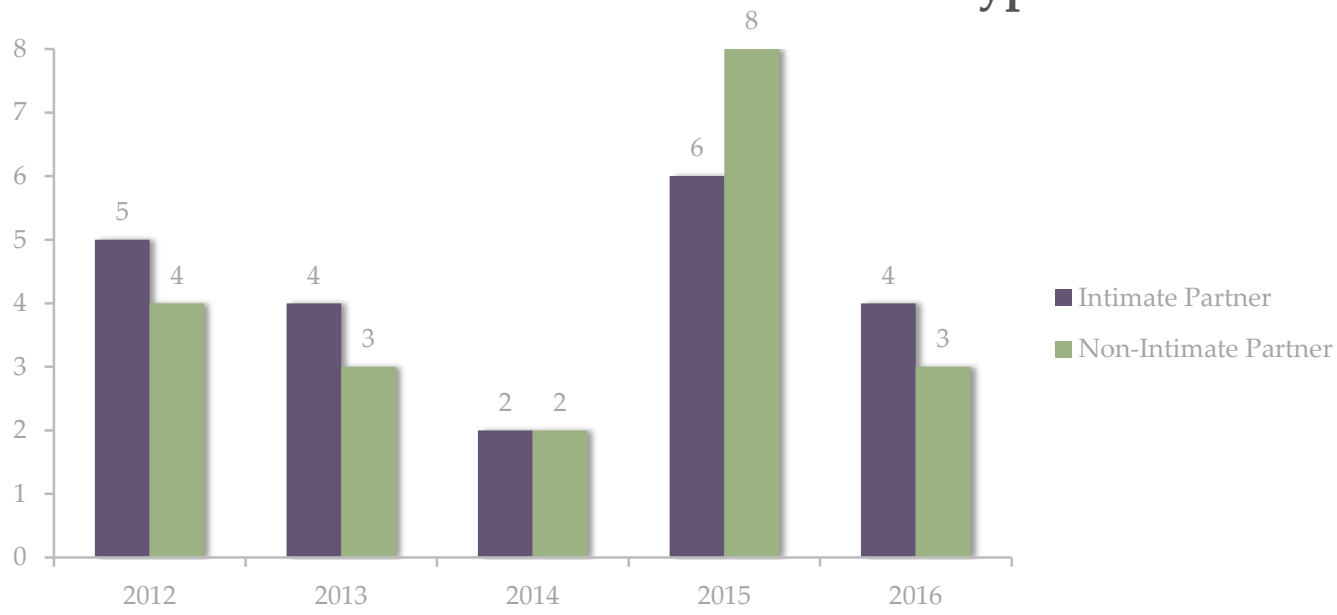
	2012	2013	2014	2015	2016
Nashville Domestic Violence Homicides	9	7	4	14	7
Nashville DV Homicides as Percentage of Total Homicides	14.5%	18%	9.7%	19.4%	8.3%
Statewide DV Homicides as Percentage of Total Homicides	20.5%	25.8%	22.1%	23.3%	19.3%

Domestic Violence Homicides by Zip Code 2012-2016



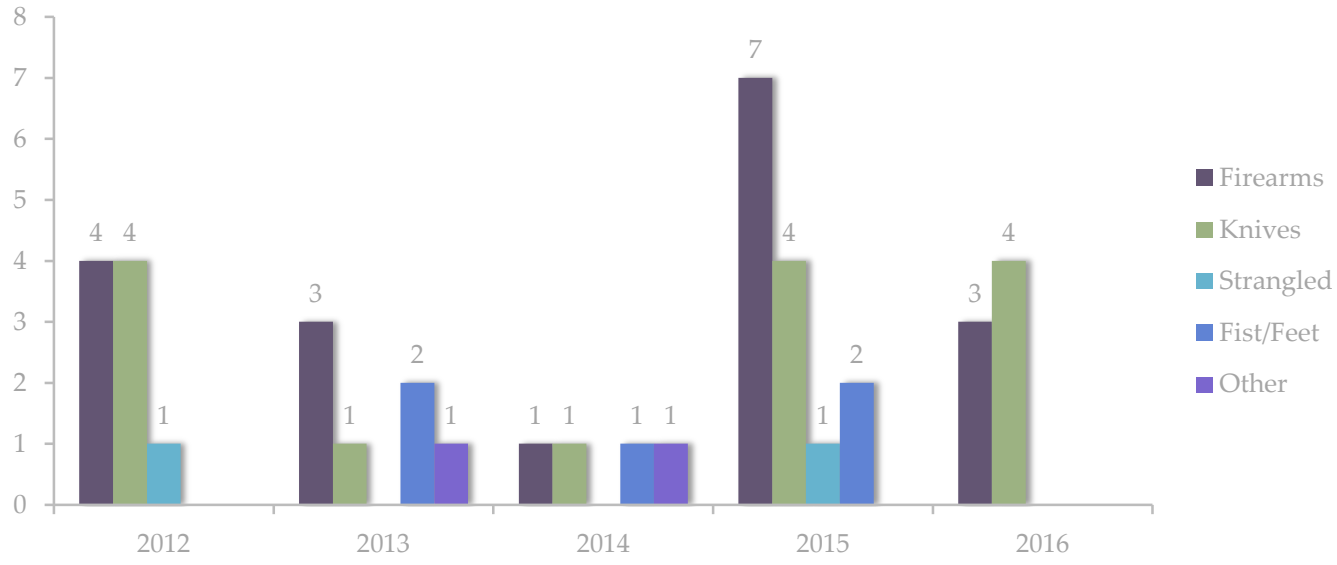
The map above shows the number of domestic violence homicides that took place within a given zip code in Nashville-Davdison County between 2012 and 2016.

Domestic Violence Homicide Type



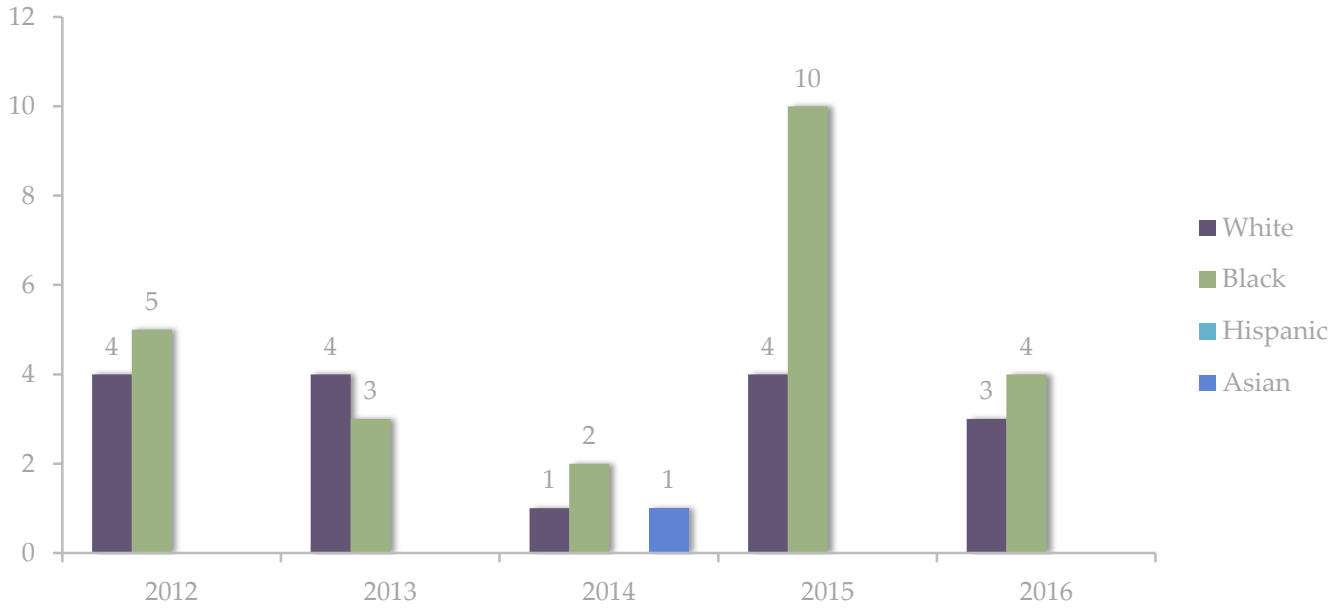
There were a total of 41 domestic violence homicides between 2012 and 2016. The average domestic violence homicide rate per year over the past five years is 8 deaths per year with 4 being the lowest number of deaths in a year and 14 being the highest. Intimate partner homicides and non-intimate partner homicides were almost equal, with 51% of domestic violence deaths perpetrated by an intimate partner and 49% by a non-intimate partner.

Weapons Used



Weapons used in the commission of the homicide vary from firearms to an individual's hands. From 2012 to 2016, the primary weapons used were firearms or knives, with 44% of homicides committed with a firearm and 34% with a knife. Additionally, 12% of deaths were perpetrated with hands/feet and 5% were strangulations.

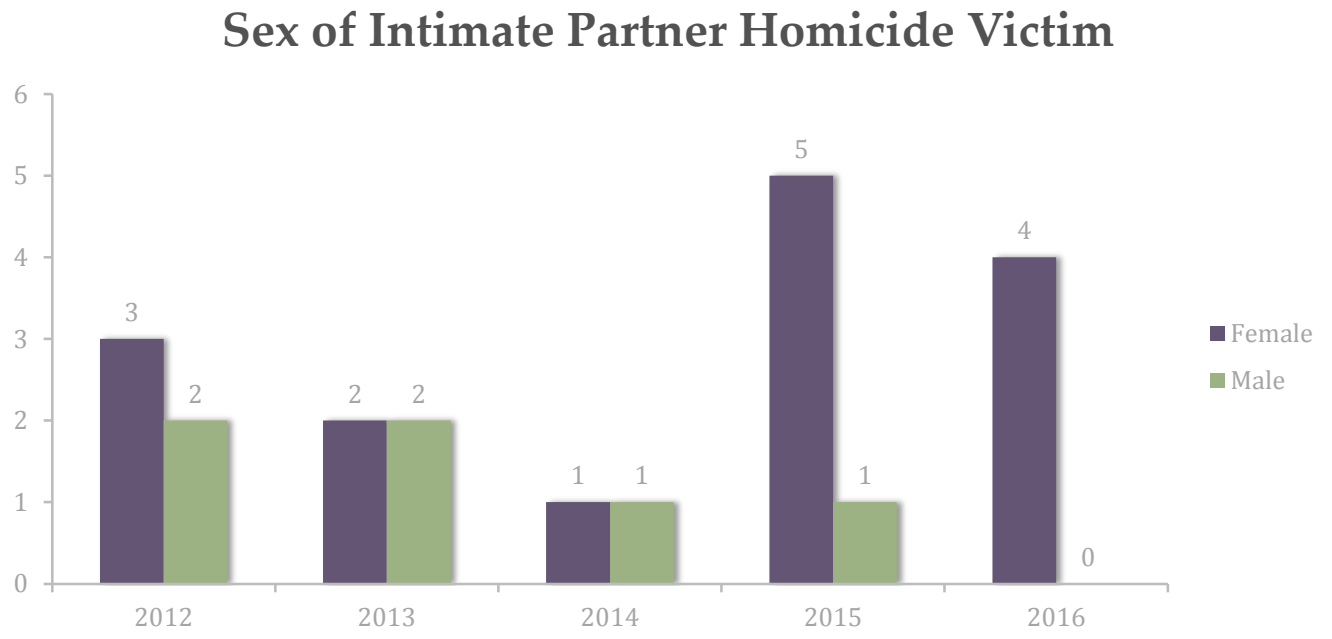
Victim Race



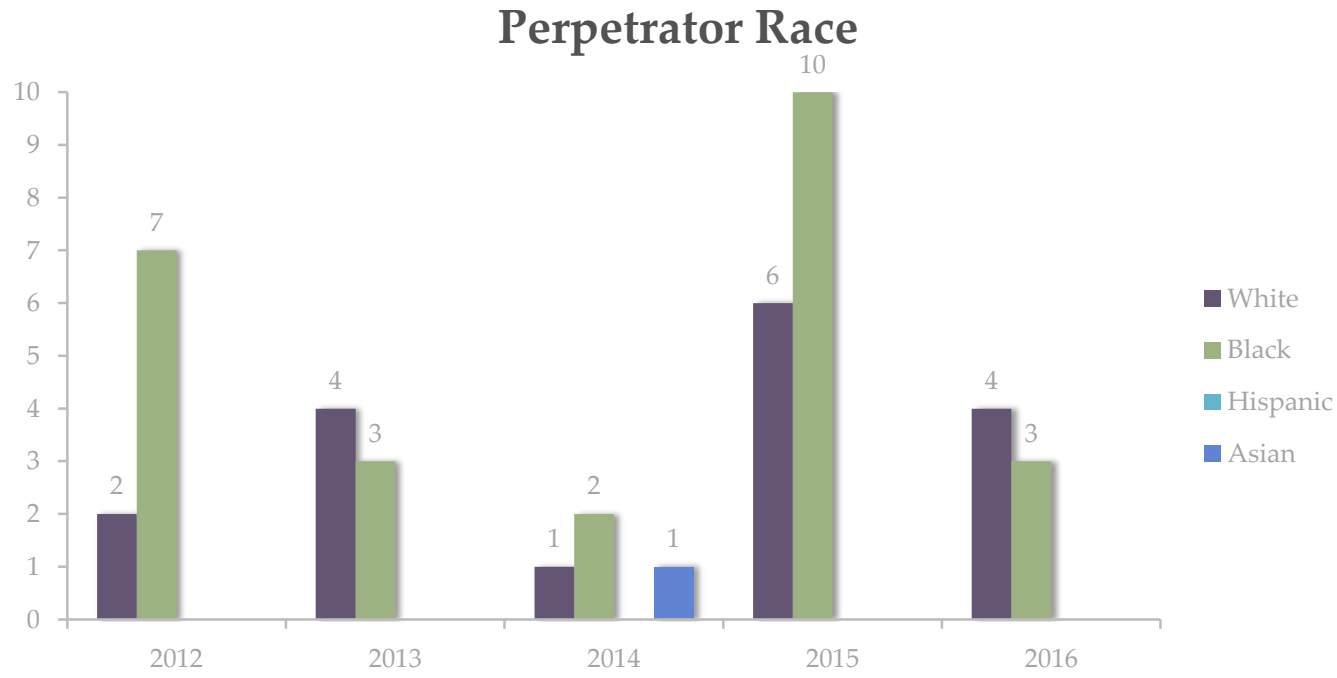
Over the 5-year period, African Americans made up 59 % of domestic violence homicide victims, Caucasians accounted for 39% of victims, Asians made up 2% of victims, and Hispanics accounted for less than 1%.

Sex of Victim

Men were slightly more commonly victims of all domestic violence homicides, during the 5-year period in Nashville. 56% of domestic violence homicide victims were male and 44% of domestic violence homicide victims were female. These figures include intimate partner and non-intimate partner domestic homicides.

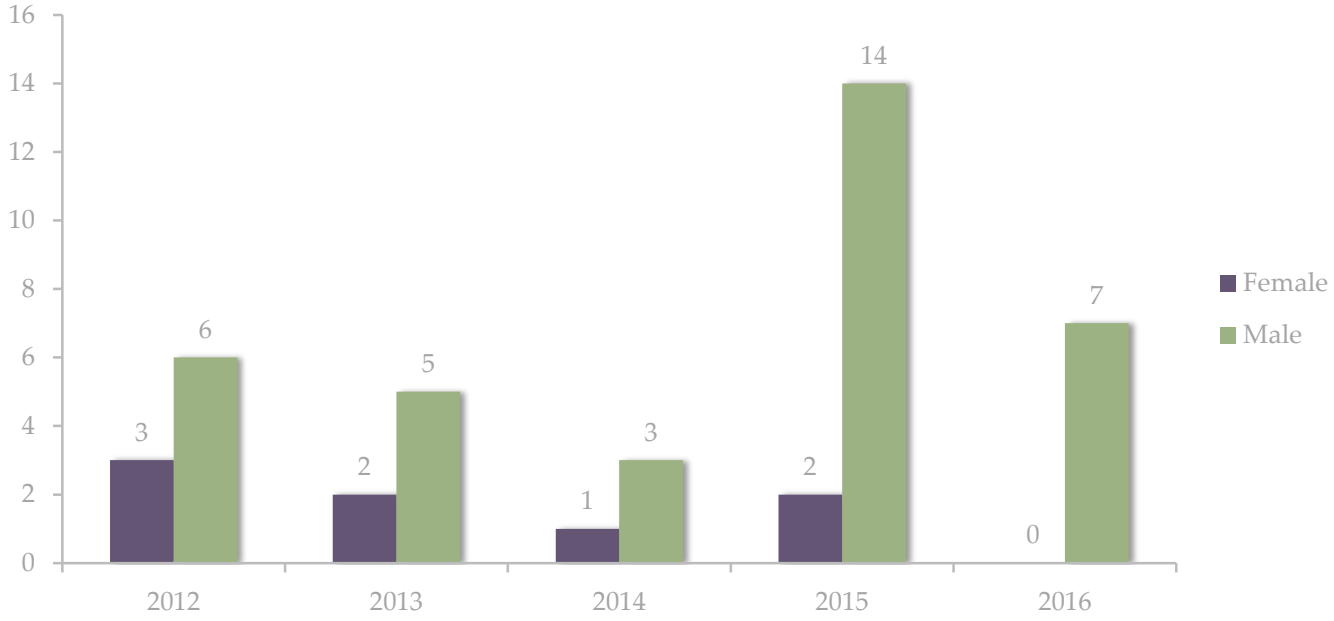


Conversely, women were more commonly victims of homicide when looking exclusively at intimate partner homicides and removing non-intimate partner cases (family, roommates). 71% of victims were female and 29% were male. Additionally, of the 6 male victims, 1 male victim was the victim of homicide by a male intimate partner and 2 male victims of homicide by female intimate partners were ruled justifiable.



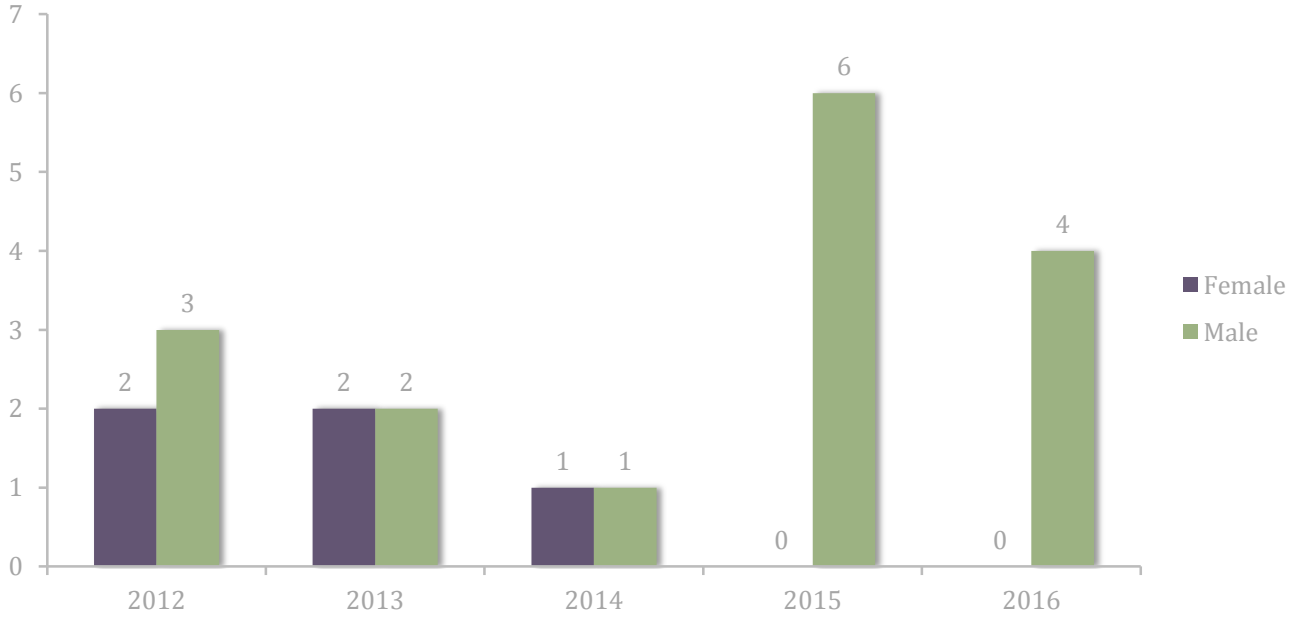
From 2012-2016, 58% of domestic violence homicide perpetrators were African American, 40% were Caucasian, 2% of perpetrators were Asian, and less than 1% were Hispanic.

Sex of Perpetrator



During the 5-year period analyzed, males accounted for 81% of DV homicide perpetrators, while females accounted for 19%.

Sex of Intimate Partner Homicide Perpetrator



Finally, when looking specifically at intimate partner homicides and removing non-intimate partner cases (family, roommates), perpetrators were also overwhelmingly male. During the 5-year period, 76% of perpetrators of intimate partner homicide were male and 24% were female. Of the 5 cases where the perpetrator was female, 2 of the cases were ruled justifiable homicides.

DOMESTIC ABUSE DEATH REVIEW (DADRT) CASE REVIEW

Case Review Process

The Domestic Abuse Death Review Team (DADRT) conducts an in-depth review of a minimum of one domestic violence fatal or near-fatal incident per year. Selected cases must be considered "closed cases" by both the Police Department and the District Attorney's Office. At a minimum, six months must have elapsed from the time of death in order to interview family members and other individuals who knew the victim and perpetrator.

The case reviewed in 2016 was presented along with three additional domestic violence homicides dating back to 2011. The Domestic Violence Division (DVD) of the Police Department also attempted to narrow down the near-fatal domestic violence incidents for potential case selection, but this proved highly challenging with over 700 near-fatal cases to evaluate. As a result, the Team examined and discussed all proposed cases and selected the reviewed case based on the lengthy history of domestic violence charges on the perpetrator and history of domestic violence incidents with the victim. The case selected was a fatal strangulation of a woman by her boyfriend.

The case review was conducted over the course of the year in six Team meetings, two interviews, and research conducted outside of meetings by Team members regarding their agency's involvement with the case. The Team reviewed police and court records to ascertain the histories of both the victim and the perpetrator in the criminal justice system. These records demonstrated an extensive criminal history of domestic violence for the perpetrator, with 17 domestic violence reports involving two other victims prior to the victim's murder and 2 domestic violence reports with a fourth victim after the victim's murder. Records also showed that the victim had an extensive history of victimization with six criminal cases from a prior relationship with her estranged husband. During the approximately three months the victim and perpetrator were in a relationship, there were no reports of abuse to law enforcement.

The Team then shared information gathered from their respective agencies, within the confines of their confidentiality guidelines, regarding any interaction with either party prior to the homicide. This information revealed that the victim had reached out for legal services multiple times to obtain assistance regarding her relationship with her estranged husband.

The Team also attempted to secure interviews from key individuals who knew the victim and the perpetrator throughout a six month period. The Team contacted five different people with requests for an interview, including the perpetrator and the victim's estranged husband, who were both incarcerated. Only one person, a family member of the victim, was able or willing to speak with the Team about the homicide. The interview with the family member was very informative, particularly regarding the victim's childhood and relationship with her estranged husband. However, in the absence of additional interviews and due to their relatively short relationship, the Team was unable to construct a comprehensive narrative of the relationship between the victim and perpetrator and the time period leading up to the homicide.

With the information gathered, the Team created several tools to assist in the review of the case. These included a timeline of key events for the victim and perpetrator, a list of known individuals surrounding the victim and the perpetrator, and a genealogy chart of the victim's family detailing histories of abuse.

Childhood

According to the family member interviewed, the victim and the victim's mother had a history of trauma and exposure to substance abuse. The victim's mother and her siblings grew up in an abusive household and suffered violence frequently at the hands of their stepfather. There was no indication that the victim herself encountered her abusive step-grandfather. The information gathered about the victim's childhood also indicated that the victim's mother abused alcohol.

When the victim was a young child, her father died by suicide in the home, possibly in front of her. There are two different accounts of the suicide from the police report and from a family member, one where the victim was present for the suicide and one where she was not present but in the home when it occurred. From the information gathered, it appears that the victim's mother did not wish for the victim to receive counseling following her father's suicide. Additionally, there was no information reported that the victim's father abused her physically or sexually; however, the Team learned that two members of the victim's family had disclosed that they had been sexually abused by the victim's father.

While the Team was not able to obtain information about the perpetrator's childhood from any interview sources, there were several incidents of truancy and runaway attempts associated with the perpetrator as a young person. Although the circumstances are unclear, these instances raise questions about childhood traumatic experiences and early onset of violent behaviors as truancy and runaway attempts can be indicators of experiencing or witnessing traumatic incidents in the family, community, or at school.

Adulthood

The victim had an extensive history of victimization from her estranged husband with six domestic violence reports where she was listed as the victim. These charges included serious incidents, such as strangulation and an assault while the victim was pregnant. In five of these cases, criminal warrants were obtained and in one case, there was not enough evidence to prosecute without the victim's cooperation, which she declined. The Team was unable to confirm whether the victim directly participated in the prosecution of the first criminal case; however, her husband was convicted and received a stay of execution, which increases the likelihood that she participated in prosecution. With the four additional charges, it is unclear how many times the victim came to court; however, the family member interviewed indicated that the victim typically did not come to court. The family member did confirm that the victim attended one time only to see the perpetrator, but did not indicate that she was present to the District Attorney's Office. Two of the cases were retired, one was dismissed, and one was dismissed by request of the state. The victim's estranged husband was incarcerated at the time of the victim's murder by her current boyfriend for a non-domestic aggravated assault.

When the victim was a young child, her father died by suicide in the home, possibly in front of her.

The victim also reported an incident of domestic assault by another intimate partner, but no criminal warrant was issued due to lack of information.

During the victim's abusive relationship with her estranged husband, she reached out for legal services multiple times. The victim either did not follow through with appointments for assistance with orders of protection and a divorce, or was turned down due to lack of resources or ineligibility for services. The victim was also offered assistance by detectives at the Domestic Violence Division of the Metro Nashville Police Department three times and declined offers for shelter and counseling each time.

According to the information gathered, the victim may have suffered from mental health issues at some point in adulthood. The victim also reportedly abused substances, specifically pain pills that she became addicted to following a non-domestic violence related injury. As a result of this substance abuse, the victim and her estranged husband had a child that had severe health issues at birth and required special care. When the victim's child was still very young, the Department of Children's Services took custody of the child and the child was adopted.

As for the perpetrator, he had 17 domestic violence incidents prior to the victim's homicide with two other women and two additional incidents with a fourth victim afterwards. These charges included simple and aggravated assaults, rape, false imprisonment, order of protection violations, and harassment. He was convicted of three domestic violence charges before the homicide. From these convictions, he was ordered to serve 50 days in jail with two for one credit (or 25 days) and to a total of 21 months of probation. The perpetrator was arrested a total of 24 times with 41 charges for the domestic violence crimes and various other crimes in adulthood, such as burglary, possession of controlled substance, and possession of a firearm.

Relationship between the Victim & Perpetrator

The victim and the perpetrator had been dating for a relatively short time, approximately three months, before he murdered her. Very little is known about the victim and perpetrator's relationship. In fact, the family member that was interviewed had no knowledge of the victim and perpetrator's relationship prior to the homicide. While the victim and perpetrator both have extensive domestic violence history, there were no prior reported incidents between the two parties. From information gathered, it is also suspected that the victim relied on the perpetrator for drugs. Additionally, information gathered indicated that a friend of the victim and perpetrator

Intimate Partner Strangulation

The case reviewed in 2016 was a strangulation of a woman by her boyfriend. Intimate partner strangulation is a particularly personal act, with the perpetrator committing violence in very close proximity to the victim's face. According to one study, individuals who have been strangled previously by an intimate partner are 7 times more likely to be murdered.[1]

1. Glass, Nancy, Kathryn Laughon, Jacquelyn Campbell, Anna Wolf, Carolyn Block, Ginger Hanson, Phyllis Sharps, and Ellen Taliaferro. "Non-fatal Strangulation Is an Important Risk Factor for Homicide of Women." *The Journal of Emergency Medicine.* (2008): 329-35. U.S. National Library of Medicine. Web. 07 Mar. 2017.

warned the victim about being involved with the perpetrator, stating that he was dangerous.

The victim was strangled to death by the perpetrator, her current boyfriend, in her home and was found with multiple drugs in her system at the time of her death. Shortly after the perpetrator strangled the victim, he raped and assaulted another intimate partner on two separate occasions. The victim of these assaults following the homicide indicated to a Team member that the perpetrator had a history of being aggressive towards her. The perpetrator was arrested for the sexual assaults against this victim and while awaiting trial, he was charged with the case review victim's homicide. The perpetrator was found guilty of the murder of the victim and the rape of his other intimate partner. He is currently serving a 30 year jail sentence with the possibility of two for one credit or 15 years.

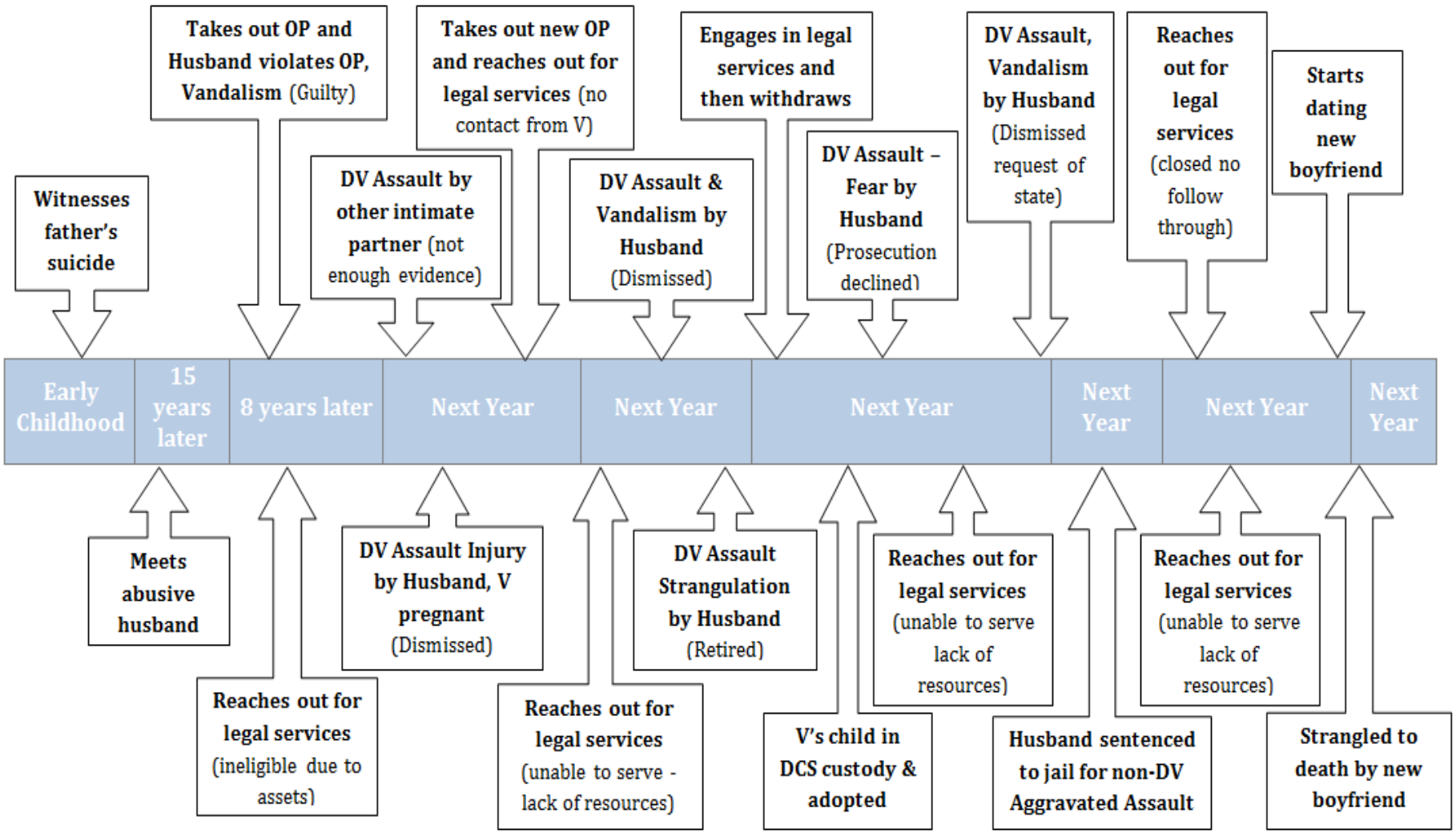
The panel is left with several unresolved questions about the brief relationship between the victim and perpetrator. There was no known contact with the criminal justice system or non-profit agencies during their relationship. The limited information known about the potential drug dependency within their relationship came from previous information disclosed to law enforcement and the District Attorney's Office by friends of the victim and perpetrator. However, these individuals were not willing or able to meet with the Team to provide more clarification around the victim and perpetrator's relationship for the review.

There were several red flags for the victim and perpetrator separately based on histories of trauma, their previous interaction with the criminal justice system, and the victim's outreach for services. For the victim, these included that she had previously been strangled and abused during her pregnancy by her estranged husband. For the perpetrator, he had strangled an intimate partner, had used and had access to a firearm, and ultimately, raped an intimate partner. While we are aware of these lethality indicators from other relationships, it is unclear what indicators were present between the two individuals during their relationship due to the lack of available information.

What is evident is that the victim came to the relationship with significant experiences of abuse from an intimate partner and the perpetrator had substantial experience committing violence against multiple victims. The potential normalization of relationship violence from these experiences may have contributed to the rapid escalation of violence in this case.

To put the events of this case in context, below are timelines for both the victim and the perpetrator with the information uncovered by the review.

Victim Timeline of Events (specific years not listed due to confidentiality)

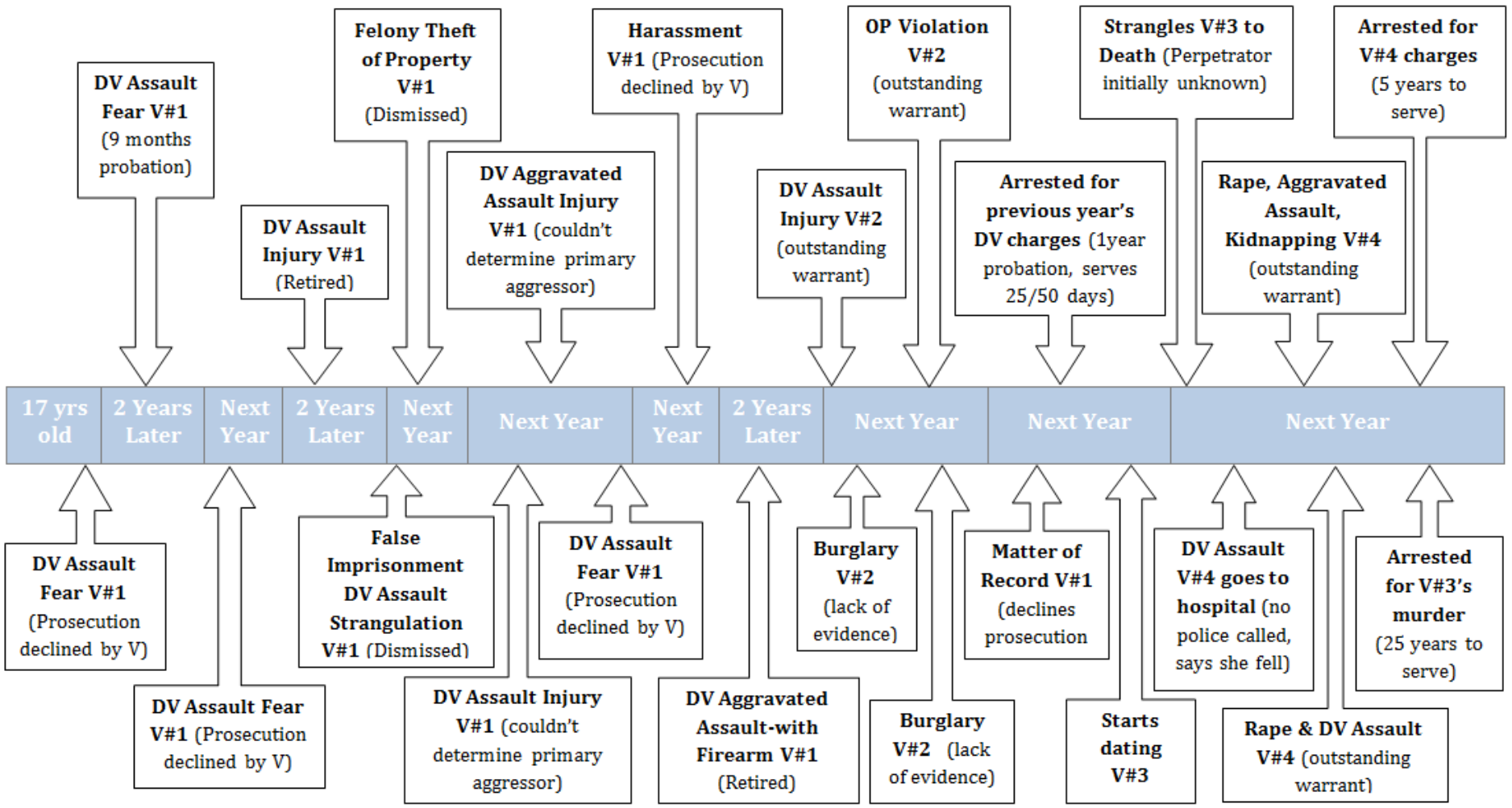


*OP = Order of Protection

*DV = Domestic Violence

*V = Victim

Perpetrator Timeline of Events (only including known intimate partner violence incidents, specific years not listed due to confidentiality)



*OP = Order of Protection

*DV = Domestic Violence

*V = Victim

KEY FINDINGS & RECOMMENDATIONS

It is important to note that at the time of this incident there were several domestic violence response systems not yet in place. The following programs are currently active but were not in place at the time:

- *Lethality Assessment Program (LAP)* screen is administered by law enforcement to all victims of intimate partner violence who call for law enforcement assistance and victims that screen in as high risk are connected on-scene with the YWCA's crisis hotline (implemented December 2016).
- *High Risk Intervention Panel (HRIP)* reviews the highest risk domestic violence cases to improve coordination between agencies and ensure victim safety and offender accountability (established in 2012).
- *District Attorney's Domestic Violence Unit* is a specialized unit that exclusively prosecutes domestic violence cases (reestablished in 2012).
- *District Attorney's Office Early Intervention Meetings (EIM)* where DAs and Victim Witness Coordinators contact domestic violence victims within 48 hours of the incident and schedule a meeting to reduce attrition in victim case involvement. (implemented in January 2016).
- *Jean Crowe Advocacy Center (JCAC)* is a court-based Family Justice Center that provides court advocacy, safety planning, and needs and danger assessments for individuals with court cases and/or seeking orders of protection (established in September 2014).
- *Civil-Legal Advocacy Program* is a collaboration between the Metro Nashville Office of Family Safety and the Legal Aid Society to provide free civil legal representation to high risk victims of domestic violence, sexual assault and stalking who file Orders of Protection (began in December 2015).
- *Handle With Care* is a program where law enforcement inform schools that a child should be treated with care after exposure to violence, drugs or other traumatic experiences (pilot in 2017).
- *Training on Strangulation & Trauma for MNPD Officers* was provided through in-person training from a national expert on strangulation and a video training on how trauma affects victims of domestic violence (occurred in 2016).
- *YWCA's AMEND Together Program* is a primary prevention initiative to end violence against women and girls by engaging boys in community-based programming in Nashville area schools (created in 2015).
- *You Have The Power (YHTP) Bullying Program* educates middle school children on bullying and appropriate behavior (2014) and the *Victim Impact Curriculum* educates 16-24 year olds on victimization using ACE-informed curriculum (2016).
- *AWAKE Healthy Relationships & Finances* (2015) *& CARE Truancy Project* (2016) educates at-risk students about healthy relationships and supports students and families in truancy proceedings.

As a result, many of the recommendations from the findings incorporate programs that are already in place or are in a new or piloting phase.

Finding #1: The victim experienced traumatic events as a child.

Research suggests that exposure to traumatic violent incidents, in the home or in the community, can adversely affect the physical, mental and emotional well-being of children into adulthood.[2] Children may be more likely to suffer a mental illness, struggle with school, abuse drugs, and engage in criminal activities.

The victim's experience with childhood trauma is evident from the case review, particularly with her father's suicide, which she either witnessed or was in the home when it occurred. Parental suicide is particularly traumatic for children, especially if the child is a witness. Children with a parent who dies by suicide are more likely to exhibit anxiety, anger, and shame and demonstrate lifetime risk factors.[3]

Additionally, it was reported that the victim's mother abused alcohol and therefore, the victim may have been exposed to substance abuse as a child. Parental substance abuse has been connected to ongoing behavioral problems in children, such as adolescent drug use.[4]

Finally, the victim's mother and her siblings suffered extreme abuse in their childhoods and this generational violence may have had a significant impact on the victim's mother and could have affected the victim's childhood. Research suggests that females who have been exposed to domestic violence in their childhood are more likely to be victims in adulthood, whereas males are more likely to perpetrate domestic violence as adults.[5]

The perpetrator's experience with childhood trauma is unknown by the panel; however, he had several incidents of truancy and runaway attempts, which can be indicators of a variety of issues for a child.

Recommendation: identify children who have experienced trauma and address it through:

- **Handle With Care (HWC)** program where law enforcement informs schools that a child should be treated with care after an incident where the police respond and a child is present
- **Increased access to therapy/counseling** within schools
- **Adverse Childhood Experiences (ACEs)** identification of childhood trauma through ACE scores
- **Increased resources for affordable community counseling** for children and families

Recommendation: increase early positive role modeling and healthy relationships education through programs in elementary, middle, and high schools, such as:

- **YWCA's AMEND & Girls Inc.** programs that work with young men and young women on healthy relationship education
- **You Have The Power (YHTP) Healthy Relationships & Bullying Prevention** programs that educate middle school through college age young people on relationships and bullying prevention

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[2] David Finkelhor, Heather Turner, Anne Shattuck, Sherry Hamby, and Kristen Kracke. "Children's Exposure to Violence, Crime, and Abuse: An Update." *OJJDP Juvenile Justice Bulletin*. Office Of Juvenile Justice And Delinquency Prevention, Sept. 2015. Web. 5 Mar. 2017.

[3] Cerel, Julie, Mary Fristad, Elizabeth Weller, and Ronald Weller. "Suicide-Bereaved Children and Adolescents: A Controlled Longitudinal Examination." *Journal of the American Academy of Child & Adolescent Psychiatry* 38.6 (n.d.): 672-79. *Suicide-Bereaved Children and Adolescents: A Controlled Longitudinal Examination - ScienceDirect*. Web. 07 Mar. 2017.

[4] Risk factors for adolescent substance abuse and dependence: data from a national sample. *Kilpatrick DG, Acierno R, Saunders B, Resnick HS, Best CL, Schnurr PP. J Consult Clin Psychol. 2000 Feb; 68(1):19-30.*

[5] *Whitfield, C., Anda, R., Dube, S., and Felitti, V. (2003). "Violent childhood experiences and the risk of intimate partner violence as adults." Journal of Interpersonal Violence, 18(12).*

- **Sexual Assault Center (SAC) Safe@Last personal safety curriculum** for children K-6th grade and **Be. program** that focuses on promoting healthy relationships for middle and high school students
- **AWAKE Healthy Relationships, Finances, & Truancy Intervention Project** programs that work with young people in schools to improve relationships, financial literacy, and combat truancy

Finding #2: Substances were abused by the victim's mother & by both the victim & perpetrator.

While the specifics of the victim's mother's problem with substance abuse are unclear, the victim may have been exposed to some level of substance abuse during her childhood. In adulthood, the victim reportedly abused substances and became addicted to pain pills following a non-domestic violence related injury she sustained. The victim had a child who was affected by her substance use during the pregnancy and the child had multiple health issues as a result.

It also appears that the victim depended on the perpetrator for drugs in some way. Though it is unclear what the reliance on the perpetrator to supply the victim with drugs looked like, substance abuse may have played a role in the power and control in their relationship, with the perpetrator withholding substances in order to exhibit the control he had over the victim given her addiction. Additionally, according to information relayed to the Team, substance abuse appeared to inhibit the victim from following through with services during her abusive relationship with her estranged husband.

Recommendation: identify and understand the impact of substance abuse on domestic violence cases through:

- **Increased training** for domestic violence agencies on substance abuse and domestic violence
- **Increased awareness of and services to** drug endangered children
- **Increased availability of treatment** programs for domestic violence victims

Finding #3: The victim did not follow through with services and participated minimally in prosecution.

The victim reached out for legal services multiple times but did not follow through. It also appears she only came to two court dates for crimes in which she was the victim, and at one of these she did not make herself known to prosecutors. According to information acquired by the Team, the lack of follow through with services may have been linked to the victim's issues with substance abuse. While incomplete, the victim's outreach for services demonstrates a desire to leave an abusive relationship that was unrealized.

At the time of the homicide as well as with prior cases, there were several programs that were not in existence that could have helped the victim engage with services and/or prosecution. These include the Lethality Assessment Program (LAP) that screens domestic violence victims for lethality and connects them to the YWCA; the High Risk Intervention Panel (HRIP) that reviews high risk domestic violence cases and helps connect victims to services; the DA's Office Early Intervention meetings (EIM) that reach out to victims immediately following domestic violence crimes to engage them in the prosecution of the case; and the Civil Legal Advocacy (CLA) Program that provides free legal representation on the orders of protection.

Additionally, the Jean Crowe Advocacy Center (JCAC), which is a court-based Family Justice Center, was not in place and may have been able to encourage engagement in services and prosecution, such as safety planning, needs assessment, and court advocacy. Finally, the forthcoming Family Justice Center, to be

completed in 2018, will provide co-located services outside of the court environment and may encourage engagement from victims reluctant to participate in the criminal justice process.

Recommendations: create additional avenues for outreach and support for victims that do not follow through with services or prosecution through:

- **Advocate-Initiated Outreach and increased interagency service coordination** as part of Metro Nashville's Lethality Assessment Program (LAP) and the High Risk Intervention Panel (HRIP)
- **Continued immediate outreach** to domestic violence victims within 48 hours of criminal incidents for District Attorney's Office Early Intervention Meetings (EIM) to reduce attrition
- **Civil Legal Advocacy (CLA) Program** free order of protection legal representation for victims of domestic violence
- **Family Justice Center (FJC) wrap-around services** with the Jean Crowe Advocacy Center (JCAC) in the courthouse and the forthcoming Center to be built in 2018

Finding #4: The perpetrator was arrested multiple times for domestic violence crimes and served minimal time in jail.

The perpetrator had 17 reports for domestic violence charges prior to the homicide, many serious in nature, and served 50 days at two for one credit (or 25 days) in jail and was ordered to 21 months of probation for these crimes. The minimal consequences for these crimes was likely due to a number of factors, primarily from a lack of participation by victims or witnesses and the inability to proceed with a victim-less prosecution. Lack of participation in domestic violence cases can stem from various factors such as fear of retaliation from the abuser, reliance on the abuser financially, belief that the abuser will change, and overall attrition from the time the incident occurs to the time the case is heard in court, causing for decreased engagement in the process. Furthermore, at the time these crimes were committed, domestic violence laws did not build on each other with enhanced sentencing for subsequent crimes. The absence of serious criminal consequences for domestic violence communicates a lack of accountability or severity surrounding these crimes.

Additionally, the perpetrator was convicted of a domestic violence assault early in his criminal history and therefore, should not have been able to possess a firearm. However, there were several subsequent reports in which the perpetrator was found to have a firearm and used it in the commission of crimes. At the time of these crimes and currently, there is no consistently followed process for dispossession of a firearm for domestic violence offenders even though it is required by state and federal laws.

Recommendations: enhance criminal justice system response to intimate partner violence cases through:

- **Intimate partner violence–specific dockets** to focus on these complicated cases involving power and control and further hone in on high risk intimate partner violence cases
- **Decreased turn-around time from incident to court resolution** to reduce attrition of victim participation and support victim safety
- **Enhanced sentencing** for subsequent domestic violence convictions
- **A clear and effective firearms dispossession process** for domestic violence offenders

- **Continued case review to improve offender accountability through the High Risk Intervention Panel (HRIP)** through weekly review calls and monthly review meetings of the highest risk intimate partner violence cases.

Finding #5: The victim had several high risk indicators that she could be a victim of future, potentially lethal violence and the perpetrator had several high risk indicators that he could perpetrate future, potentially lethal violence. Additionally, their previous abusive relationships may have normalized high levels of violence and rapidly escalated the violence in their brief relationship.

At the time of and prior to the homicide, there were no danger or lethality assessments in use by Metro domestic violence partners that could have alerted law enforcement, prosecutors, and victim service providers to the risk of lethality for the victim and perpetrator. Additionally, there was no multi-disciplinary team to review these cases and coordinate responses to high risk victims and perpetrators. As indicated previously, there were several high risk factors on both the side of the victim and perpetrator's prior histories that would have been captured by a screening tool and reviewed by a team.

The Lethality Assessment Program (LAP) that screens domestic violence victims at the scene of the crime would have likely indicated a number of high risk factors for both the victim of this homicide and the other victims of the perpetrator. Additionally, the current High Risk Intervention Panel (HRIP) could have been utilized to respond to any of these cases and focus on how to ensure the victim's safety and hold the offender accountable for his continued crimes.

An evidence-based risk assessment tool would also be beneficial to evaluate offenders upon conviction. A probation high risk screening tool and corresponding tiers of probation related to the seriousness of risk would enhance offender treatment. Additionally, victim service providers currently do not use one standard lethality assessment.

Finally, the Team's theory that the victim and offender's previous abusive relationships contributed to rapidly escalating and fatal violence in their relationship, a "relational risk transfer", should be examined in more detail.

Recommendations: continue to utilize and enhance the use of the following tools and programs:

- **Lethality Assessment Program (LAP)** to identify high risk cases to connect to the YWCA and additional services, follow-up by DV Detectives, and potential inclusion on HRIP.
- **High Risk Intervention Panel (HRIP)** weekly Advisory Committee calls review highest risk cases and monthly all-Panel meetings conduct an in-depth review of cases selected by the Committee.

Recommendations: to formalize the use of the following tools and programs:

- **Evidence-based high risk offender identification screen** for probation and parole
- **High risk offender probation** with different tiers for different risk levels and corresponding enhanced supervision
- **Evidence-based high risk victim identification screening** for victim service providers
- **Relational Risk Transfer** research needed on potential lethality of these cases

IMPLEMENTATION PLAN

Finding #1 – Childhood Trauma		
Recommended Action	*Status*	*Needed for Success*
Handle With Care (HWC)	▪ Domestic Violence Division (DVD) has trained officers on HWC ▪ DVD is working with Martha O'Bryan Center and MNPS to pilot HWC ▪ OFS secured grant funding for a full-time MNPD employee to manage HWC	▪ MNPS to allow HWC in more schools for a pilot and then expand to all schools ▪ New HWC employee to create seamless process for HWC reports
Increased access to therapy, counseling within schools	▪ There is one counselor per school, with a total of 102 in Elementary, 58 in Middle, 91 in High School ▪ There are 47social workers that rotate between 1 to 4 schools at a time.	▪ Increase number of full-time counselors, including those with ability to work after hours and do home visits ▪ Every Nashville School should have a full-time social worker
Identification of childhood trauma through Adverse Childhood Experiences (ACEs)	▪ Tennessee ACEs Initiative is a partnership through the State of Tennessee to prevent ACEs ▪ Tennessee ACEs Initiative provides ACEs Train-the-Trainers ▪ ACE Nashville is an initiative of individuals, organizations and institutions working together to prevent and alleviate ACEs ▪ Metro Health Dept. has a new full-time ACEs Prevention Coordinator	▪ ACEs Train-the-Trainer should be attended by key staff members from all DV organizations and agencies ▪ Mandatory trainings on ACEs should be provided for all Metro Nashville Government Departments, MNPD, & MNPS ▪ Increase coordination between DV efforts and ACEs efforts in Nashville.
Increased resources for affordable community counseling for children and families	▪ DV counseling in YW shelter ▪ DV counseling at DVD Counseling Unit, funding for 2 new positions secured ▪ DV counseling at Martha O'Bryan Center grant ends September 2017	▪ Increased funding to expand counseling availability in the community for victims and their children
Increase early positive role modeling and healthy relationships education through programs in elementary, middle, and high schools	▪ YWCA's AMEND & Girls Inc ▪ YHTP Healthy Relationships & Bullying Prevention ▪ SAC Safe@Last and Be. programs ▪ AWAKE Healthy Relationships, Finances, & CARE Truancy Program	▪ All prevention programs should coordinate with each other in their efforts and identify gaps in course provision for Nashville's youth ▪ Increased coordination with MNPS to identify schools that are not providing this programming

Finding #2 – Substance Abuse		
Recommended Action	*Status*	*Needed for Success*
Increased training of DV agencies on substance abuse and DV	▪ YWCA, YHTP, and the Office of Family Safety provide trainings on domestic violence ▪ OFS has secured funding to offer DV education for female inmates and recently incarcerated women.	▪ Update trainings with information on working with victims with substance abuse ▪ Develop inmate curriculum on DV, sexual assault, sexual exploitation that incorporates substance abuse information
Increased awareness of and services to Drug Endangered Children (DEC)	▪ Nashville does not have a local chapter working on DEC and the TN Alliance for DEC is currently in a rebuilding phase	▪ Consider developing a Nashville DEC chapter to increase awareness, education, & response to DEC
Increased availability of treatment programs for DV victims	▪ Renewal House, The Next Door, and Mending Hearts provide substance abuse services for women	▪ Increase the collaborative network providing services ▪ Increase funding for treatment, especially for women with children

Finding #3 – Victim lack of follow through with services or prosecution		
Recommended Action	*Status*	*Needed for Success*
Advocate-Initiated Outreach and increased interagency service coordination as part of Metro Nashville's Lethality Assessment Program (LAP) and the High Risk Intervention Panel (HRIP)	▪ LAP screen links victims to the YWCA while officers are on-scene. ▪ YWCA can facilitate a "warm hand-off" call with the victim to the JCAC or DVD Counseling ▪ YWCA can request that JCAC or DVD initiate follow-up with a victim ▪ HRIP reviews highest risk cases for service needs ▪ HRIP can help identify who is the best person to reach out to a victim	▪ Additional funding for YWCA hotline volume increase created by LAP. OFS received grant funding for 1 additional position at the YW. ▪ Additional personnel for advocate-initiated outreach and counselors at the YWCA, JCAC and DVD. OFS has received grant funding for advocates to conduct this outreach.
Continued immediate outreach to domestic violence victims within 48 hours of criminal incidents for District Attorney's Office Early Intervention Meetings (EIM) to reduce attrition	▪ DA's Office reaches out to DV victims within 48 hours to schedule an EIM to engage victims in court proceedings ▪ After EIM, almost 100% of victims are brought to JCAC for services ▪ Even within 48 hours, victims may decide not to cooperate with prosecution ▪ Court-house location of EIMs may be inconvenient or intimidating	▪ Continued collaboration between Victim Witness Coordinators (VWCs) and JCAC advocates ▪ EIMs should move to the new Family Justice Center when finished to be more accessible and potentially less intimidating to victims outside the court-house setting

Civil Legal Advocacy (CLA) Program free order of protection (OP) legal representation for DV victims	▪ JCAC identifies victims in need of free legal representation on OPs ▪ Legal Aid Society matches individuals with a pro-bono attorney to provide this service ▪ Currently, there are not enough pro-bono attorneys to meet demand ▪ Pro-bono attorneys are unable to take cases with a criminal case attached due to the OP and criminal case being combined. When this happens, the OP is continued frequently with the criminal case.	▪ Increase outreach to pro-bono attorneys to meet demand for OP representation ▪ OPs and criminal cases should be heard separately to avoid dangerous delay in OP hearing and to ensure that pro-bono attorneys are able to represent victims. This would also decrease OPs being used as a bargaining tool in the criminal case.
Family Justice Center (FJC) wrap-around services with the Jean Crowe Advocacy Center (JCAC) in the courthouse and the forthcoming FJC	▪ JCAC provides services from 8am-4pm Monday through Friday in the courthouse ▪ New FJC is slated for completion in late 2018 and will include multiple co-located partner organizations	▪ Funding to hire advocates for the new FJC ▪ New FJC should staff advocates 24 hours a day, 7 days a week

Finding #4 – Offender Accountability		
Recommended Action	*Status*	*Needed for Success*
Intimate partner violence (IPV)–specific dockets to focus on these complicated cases and further hone in on high risk IPV cases	▪ DV dockets include both intimate partner and non-intimate partner (family, roommates) cases ▪ DV dockets are very full and time consuming, potentially not allowing for focus on high risk cases	▪ Separate non-intimate partner domestic violence cases from IPV cases in court dockets ▪ More focused review of IPV lethality factors (*see also High Risk Recommendations*)
Decreased turn-around time from incident to court resolution to reduce victim participation attrition and support victim safety	▪ Jail DV cases in GS Court took an average of **8.3 days** from arrest to disposition in 2016. ▪ Bond DV cases took **72.4 days** on average from arrest to disposition in GS Court in 2016. ▪ Criminal Court DV cases in jail disposed in Criminal Court took **110.9 days** on average in 2016. ▪ Criminal Court DV cases on bond took **250.9 days** on average from CC filing to disposition in 2016	▪ Decrease time between incident and case resolution substantially in all cases, particularly Criminal Court cases and Bond GS Court cases ▪ Decrease may necessitate increase in court staff or separation of intimate and non-intimate partner DV cases
Enhanced sentencing with standard requirements for DV convictions	▪ 3rd or subsequent DV conviction must include a minimum 90 day, day for day jail sentence	▪ Procedural clarity is needed between judges, prosecutors, defense attorneys, and clerks to

Enhanced sentencing with standard requirements for DV convictions (continued)	▪ Any DV conviction following 2 priors is an E Felony ▪ Procedural errors with DV judgments appear to have resulted in some perpetrators not receiving day for day sentencing ▪ Anger Management Classes (AMC) can be offered instead of Batterer's Intervention Programs (BIPs) ▪ 16 week BIPs are available ▪ Substance abuse treatment isn't always included for individuals with both DV & Substance Abuse issues ▪ No differentiated probation screening and treatment for high risk offenders	ensure correct sentencing under law ▪ AMCs should not be offered on intimate partner violence cases ▪ BIPs should be offered at a minimum of 26 weeks for intimate partner violence cases ▪ Screen all DV offenders for substance abuse issues to ensure dual treatment ▪ Develop or adopt a high risk probation screening to identify high risk offenders (*see also High Risk Recommendations*)
A clear and effective firearms dispossession process for domestic violence offenders	▪ There is no standard protocol for dispossession for DV perpetrators or respondents on OPs ▪ Offenders and respondents are able to dispossess to a third party (often a friend or family) without proof ▪ Victims are not able to object to whom the firearm is dispossessed ▪ There was an unsuccessful initiative to move all OP cases to Circuit Court and include a firearms dispossession hearing	▪ Clear protocols for firearms dispossession ▪ Funding for court personnel to provide hearings to confirm dispossession ▪ Legislative change to remove the option of third party dispossession as an ineffective option for dispossession ▪ Funding for MNPD to store dispossessed firearms
Continued high risk case review to improve offender accountability through the High Risk Intervention Panel (HRIP)	▪ Law enforcement, prosecutors, and probation/parole employ strategies to hold high risk offenders accountable and can coordinate through HRIP meetings	▪ Pre-trial dangerousness hearings to increase protective measures ▪ Increased availability of electronic GPS monitoring

Finding #5 – High Risk Identification		
Recommended Action	*Status*	*Needed for Success*
Lethality Assessment Program (LAP)	▪ LAP identifies high risk cases to connect to the YWCA and additional services, over 6000 LAPs administered since December 2016 to the time of this report release November 2017	▪ Data coordination to ensure that all court entities are made aware of offender's high risk nature from the LAP ▪ Additional funding for YWCA hotline volume increase created

Lethality Assessment Program (LAP) (continued)	▪ Approximately 60% of IPV cases or 320 per month screen in an high risk through the LAP ▪ LAPs sent to DVD, DA's Office, OFS, and YWCA ▪ Approximately 19 LAPs are entered manually each day by OFS and sent to HRIP Advisory Committee ▪ LAPs with a significant number of lethality indicators are discussed in a weekly HRIP Advisory Committee call and ultimately considered for the monthly panel	by LAP. OFS has received grant funding for 1 additional position at the YW ▪ Additional personnel for advocate-initiated outreach and counselors at the YWCA, JCAC and DVD. OFS has received grant funding for advocates to conduct this outreach ▪ LAP automated data pull needs to be available to coordinate high risk case response among partners
High Risk Intervention Panel (HRIP)	▪ HRIP Advisory Committee weekly review call on highest risk cases reviews 10-15 cases depending LAP score and referrals ▪ Monthly review meeting of highest risk cases reviews 5-10 cases ▪ Over 500 cases reviewed in from January 2017 to October 2017 ▪ HRIP cannot review a significant portion of cases that are high risk but don't rise to the "highest risk" level due to massive case volume	▪ Increased funding for all HRIP partners to support the work needed to review as many high risk cases as possible, ideally in a daily review. ▪ OFS has received grant funding for two new positions to support the High Risk Manager in HRIP coordination.
Evidence-based high risk offender identification screen for probation and parole & High risk offender probation	▪ Probation and Parole currently use internal assessments to identify offender risk ▪ These assessments can determine levels of supervision ▪ OFS has secured grant funding for an advocate to work with victims on high risk probation cases.	▪ Adopt evidence-based tools for DV offender risk assessment that assign tiers of supervision ▪ Coordinate a multidisciplinary treatment team including, probation/parole, treatment providers, and a victim advocate
Evidence-based high risk victim identification screening for victim service providers	▪ LAP screen is currently used by the JCAC to identify risk for DV victims, however, the screen was meant for first responders ▪ YWCA and DVD use their own tools to identify risk for DV victims	▪ Evidenced-based screening tool for service providers, the Danger Assessment, should be utilized by all service providers ▪ Funding for Danger Assessment certification for each individual utilizing the assessment is required
Research "relational risk transfer" and its impact on lethality	▪ No research found on this topic ▪ OFS has secured grant funding for two new positions to support high risk work	▪ Conduct an analysis of cases that have relational risk transfer and analyze their outcome

CONCLUSION

The DADRT annual report serves as a continual safety assessment for Nashville-Davidson County. The recommendations the Team developed from the case review will guide the work of the Metro Office of Family Safety (OFS) and its partners in our prevention and response to domestic violence. The Team proposes that each of the report's recommendations be implemented with the support and guidance of the Office of Family Safety (OFS).

The Team is confident in Nashville-Davidson County's ability to successfully implement all recommendations contained in this report. The city is well-positioned to address these recommendations due to our exceptional partnerships and multi-disciplinary approach to domestic violence, including the following collaborative partnerships coordinated by Office of Family Safety (OFS): the Lethality Assessment Program (LAP), the High Risk Intervention Panel (HRIP), the Civil Legal Advocacy Program (CLA), the Jean Crowe Advocacy Center (JCAC), the new Family Justice Center (FJC) in development, and the Domestic Abuse Death Review Team (DADRT) itself. In particular, the Team's work is supported by the work of the Lethality Assessment Program (LAP) and the High Risk Intervention Panel (HRIP) as both programs essential in reducing the rate of domestic violence homicide in Nashville by their focus on the highest risk cases.

Each of these collaborative initiatives will be housed at the new Family Justice Center on Murfreesboro Road when construction is complete at the end of 2018. This will allow co-located partners to enhance our teamwork even further with daily meetings and immediate crisis response and coordination. This co-location will amplify Nashville's ability to address each of the recommendations included in this report.

Finally, the Office of Family Safety (OFS) is honored to have been selected by the Tennessee Office of Criminal Justice Programs (OCJP) to be designated the domestic violence fatality review technical assistance provider for the state of Tennessee. The Office of Family Safety (OFS) will hire a statewide fatality review coordinator to implement our DADRT model across the state that will report to a single statewide fatality review body. This statewide body will compile data from across the state and it is our expectation that this information will shine the light on necessary legislation to reduce the State's domestic violence homicide rate.

We are excited that our Team has been recognized as a leader in our domestic violence fatality review work in the state and we are committed to continuing to enhance our work around the highest risk cases in order to prevent domestic violence homicides. The Domestic Abuse Death Review Team (DADRT) is committed to honoring the lives of domestic violence homicide victims by working tirelessly to evaluate these cases and implement life-saving changes in Nashville's service to domestic violence victims.

APPENDICES

DOMESTIC ABUSE DEATH REVIEW (DADRT) MISSION & RESPONSIBILITY & AUTHORITY OF THE TEAM

Team Mission

In accordance with Executive Order No. 016 authorized by Tennessee Code Annotated §36-3-624, the Metropolitan Government of Nashville Davidson County created the Domestic Abuse Death Review Team or DADRT to "establish an interagency domestic abuse death review team to identify and review domestic abuse deaths, including homicides and suicides, and to facilitate communication among the various agencies involved in domestic abuse cases in order to recommend improvements in the system of services to domestic abuse victims and their families, and to provide accurate information related to domestic abuse issues to the community."

Responsibility and Authority of the Team

It shall be the responsibility of the Team to identify, review, and analyze fatal or near fatal incidents of domestic violence to better understand the dynamics of these fatalities or near fatalities and to facilitate communication among the various agencies involved in domestic abuse cases. "Fatal incidents of domestic violence" means a homicide or suicide that is committed by a party to the domestic violence and not committed by an on-duty police officer acting within the scope of employment. "Near fatal incident of domestic violence" includes attempted homicides and cases where it is likely that the victim would have died but for medical intervention. It shall also be the responsibility of the Team to conduct an in-depth review of a minimum of one domestic violence fatal or near-fatal incident(s) per year. Selected cases must be considered "closed cases" by both the Police Department and the District Attorney's Office. A minimum period of two years must have elapsed from the time of death in order to interview family members and other close associations of the victim and/or perpetrator.

HISTORY OF THE DOMESTIC ABUSE DEATH REVIEW TEAM (DADRT)

Davidson County's first Domestic Violence Death Review Committee was an informal group established by the Nashville Coalition Against Domestic Violence in 1995. The mission of this committee was to 1) investigate the circumstances of each adult domestic violence fatality occurring in Davidson County and 2) identify potential improvements to the County's response system that could decrease morbidity and mortality related to domestic violence. Davidson County's current Domestic Abuse Death Review Team was formed by executive order in 2002. The team has released a number of recommendations over the years. The following table represents highlights of DADRT's recommendations from 2005-2011:

Community Awareness	
2005	The public needs to be educated about domestic violence; what it is, how it effects elderly, adult, and child victims, where and how to get help.
2005	Schools should include curricula regarding domestic violence and making good choices when forming relationships
2005	Emergency facilities, physicians, and other health care providers should screen for domestic violence and have information regarding domestic violence displayed in their offices, similar to the posting of information for abused elders required by state law (71-6-121).
2005	Local media, both print and electronic, should use public service announcements and information about recognizing signs of domestic violence and taking action to prevent domestic violence.
2005	Once every two or three years, on a regular basis, Davidson County should host a "Summit on Domestic Violence" at which all agencies, including the judicial system, come together to examine how the system is working.
Medical Services	
2007	All emergency health care providers and facilities must receive basic education and regularly scheduled updates about domestic violence.
2007	All emergency facilities, physicians, and other health care providers should screen every patient for domestic violence and make appropriate referrals, including mental health services.
2007	Signage in health facilities about domestic violence, elder abuse, and teen dating violence pursuant to state law should be in Spanish and English.
Criminal Justice System	
2005	The Metro Police Department Domestic Violence Division (DVD) should always be fully staffed at 1994 levels. In 1994, there were 22 detectives assigned to the division.
2005	The District Attorney should be funded in order to reestablish its specialized unit to prosecute domestic violence.
2005	The Domestic Violence Division and District Attorney's Office should have sufficient staff to resume working together on a weekly basis to coordinate the investigation and prosecution of domestic violence cases.

2005	The conditions of bond should be available online, in particular for police enforcement, and a copy of the conditions of bond should be given to each victim.
2006	When a batterer is found to have committed a domestic assault against an intimate partner, or as a condition of pretrial diversion for domestic assault, the court should be limited to ordering counseling by a certified batterer's intervention program or by a program that is in the process of certifying its batterer's intervention program.
2006	Funding for child trauma therapist with the DVD.
2007	For every homicide or attempted homicide arising from domestic violence, the police officer in charge should complete a standardized form prepared by the DV Death Review Team. This information shall be provided to the Team for assessment, points of intervention and grant applications.
2007	The team supports the notion of a Metro, Nashville Davidson County Forensic Laboratory.
2008-2011	DV criminal docket should be resumed.
2008-2011	Needs to be intervention for children who have witnessed or experienced domestic violence crimes. Maintain dedicated counselors at domestic violence Police Unit.
2008-2011	Police officers answering domestic violence calls and suspect that domestic violence is occurring should be required to complete the Lethality Assessment.
Civil Justice System	
2005	There should be one centralized clerk's office in which all Petitions for Orders of Protection are filed, except for middle of the night emergencies, and that office should route the petitions to the appropriate office for hearing: Circuit, General Sessions, or Juvenile.
2005	The night court commissioners should meet on a regular basis with attorneys and advocates until they develop guidelines which ensure consistency in the process of petitioning for an Order of Protection.
2005	The initial termination date of an Order of Protection should be extended beyond one year, for as long a period as is necessary to ensure the safety of the victim.
2005	No court should require an upfront fee to file a Petition for an Order of Protection.
2006	GPS monitoring for repeat abusers.
2007	Assistance for victims filing petitions for orders of protection. Victims must receive the assistance they need to achieve safety for themselves and their children.
Legislative Initiatives	
2005	Hospital emergency rooms should be required to display posters regarding domestic violence and where to find help.
2005	In cases of domestic assault, there should be an enhanced penalty when a child is present or strangulation has occurred.
2005	When a defendant is charged with a second or subsequent charge of domestic assault, the second and subsequent charges should be upgraded to felonies.
2005	In cases involving second and subsequent violations of an Order of Protection, the second and subsequent charges should be classified as criminal offenses.

2005	A $25 fee should be imposed against every batterer who is convicted of domestic assault or against whom an order of protection is entered and that fee should be directed to the Nashville Coalition Against Domestic Violence to fund a community safety audit.
Metro Government	
2006	Implement a policy in support of employee victims of domestic violence and abuse.
2008-2011	Need to have Mayor add a public relations specialist to the Death Review Team.
2008-2011	Need to have Mayor appoint a Metro Council member to the Team.
2008-2011	Everyone who works or volunteers in the Davidson County system designed to deal with domestic violence issues needs to support, cooperate with, and facilitate in every way possible a Safety Audit of the system to determine what is working, what can be improved, and what is not working.

In 2015, the Team received training from nationally-renowned expert and Director of the National Domestic Violence Fatality Review Initiative, Neil Websdale, on the structure of fatality review teams. Subsequently, the Team changed the model of the review consistent with national best practices from reviewing all domestic violence deaths in Nashville to reviewing 1 to 2 cases per year. The Team also added that near-fatal cases could be reviewed in addition to fatalities as a part of the best practices learned from this training. The Executive Order authorizing the team was updated in 2016 to reflect these changes.

DADRT EXECUTIVE ORDER

EXECUTIVE ORDER NO. 022

THE METROPOLITAN GOVERNMENT OF NASHVILLE AND DAVIDSON COUNTY

MEGAN BARRY, MAYOR

SUBJECT: Creation of the Metropolitan Government Domestic Abuse Death Review Team

WHEREAS, domestic abuse related deaths are of grave concern to all citizens of Nashville and Davidson County; and

WHEREAS, it is the responsibility of the Metropolitan Government to establish such procedures that may be necessary to reduce the incidence of domestic abuse; and

WHEREAS, the General Assembly of the State of Tennessee has enacted Chapter No. 788 of the Public Acts of 2000, to be designated as Tennessee Code Annotated §36-3-624, authorizing a county to establish an interagency domestic abuse death review team to identify and review domestic abuse deaths, including homicides and suicides, and to facilitate communication among the various agencies involved in domestic abuse cases in order to recommend improvements in the system of services to domestic abuse victims and their families, and to provide accurate information related to domestic abuse issues to the community.

NOW THEREFORE, I, Megan Barry, Mayor of the Metropolitan Government of Nashville and Davidson County, by virtue of the power and authority vested in me, do hereby direct and order the following:

Creation of Team. There is hereby created a team to be known as the Metropolitan Government Domestic Abuse Death Review Team, ("the Team").

Composition of Team. The Team shall consist of the following voting members

The District Attorney General of Davidson County or an assistant district attorney designated by the District Attorney General. The District Attorney General of Davidson County shall serve as chairperson at the initial organizational meeting.

A representative from Legal Aid Society of Middle Tennessee.

A representative with domestic violence expertise from the medical community to be appointed by the Mayor of the Metropolitan Government of Nashville and Davidson County.

A representative from the Personal Crimes Division and a representative from the Domestic Violence Division of the Metropolitan Police Department to be appointed by the Chief of Police.

The Sheriff of the Metropolitan Government or a designee of the Sheriff.

The Director of the Metropolitan Government Department of Health or a designee of the Director.

A representative of a domestic violence abuse shelter and crisis hotline provider in Davidson County to be appointed by the Mayor of the Metropolitan Government of Nashville and Davidson County.

An individual currently employed as a victim advocate to be appointed by the Mayor of the Metropolitan Government of Nashville and Davidson County.

The Chief Medical Examiner of the Metropolitan Government or a designee of the Chief Medical Examiner.

Representative of the Metropolitan Government Office of Family Safety.

Two private citizens who have demonstrated an interest in reducing the incidence of domestic abuse to be appointed by the Mayor of the Metropolitan Government of Nashville and Davidson County.

The chairperson of the Health, Hospitals And Social Services Committee of the Metropolitan Council or a designee of the chairperson.

Two representatives from non-profit groups that serve domestic violence victims and who are not already serving as a designee of the Mayor or representing any of the other agencies mentioned elsewhere in these Protocols to be appointed by the Mayor of the Metropolitan Government of Nashville and Davidson County.

Of the voting members, a minimum of one member must be a survivor of domestic violence.

Special Resource Team.

In addition to the above voting members comprising the Team, in any particular death review wherein one or more other persons may be able to provide additional appropriate information, expertise or guidance, the Team may request any of the following persons as ad hoc, nonvoting members:

The chief law enforcement officer, or a designee of the chief law enforcement officer, of any law enforcement agency, within or outside Nashville and Davidson County, that may have investigated, or assisted in the investigation of, a domestic abuse related death.

Any person with expertise in the field of criminology or mental health.

A representative from the Metropolitan Fire Department with expertise in arson investigation.

A representative of the Tennessee Department of Human Services.

Any other person or persons or representatives from other local agencies who may provide insight or guidance to the First Response Team

An individual with the appropriate clinical degree and experience to interview near death survivors and family members of deceased victims

A representative from the Tennessee Department of Children's Services.

Any member of the legal community with special expertise in victim's rights or domestic abuse.

Responsibility and Authority of the Team. It shall be the responsibility of the Team to identify, review, and analyze fatal or near fatal incidents of domestic violence to better understand the dynamics of these fatalities or near fatalities and to facilitate communication among the various agencies involved in domestic abuse cases. “Fatal incidents of domestic violence” means a homicide or suicide that is committed by a party to the domestic violence and not committed by an on-duty police officer acting within the scope of employment. “Near fatal incident of domestic violence” includes attempted homicides and cases where it is likely that the victim would have died but for medical intervention. It shall also be the responsibility of the Team to conduct an in-depth review of a minimum of one domestic violence fatal or near-fatal incident(s) per year. Selected cases must be considered “closed cases” by both the Police Department and the District Attorney’s Office. A minimum period of two years must have elapsed from the time of death in order to interview family members and other close associations of the victim and/or offender.

Toward that end, the duties and functions of the team may include, but are not limited to the following:

Identifying patterns and trends of domestic abuse in the community.

Identifying barriers to safety and justice and evaluating the services provided to the victim or their family, and reviewing what services and interventions the victim may have needed and wanted.

Identify gaps in training, policy, practice, resources, communication and collaboration.
Making recommendations for systemic improvements to services or assistance offered to domestic abuse victims.

Establishing communication paths between any agency or entity providing assistance to domestic abuse related victims and their families.

Developing a protocol for the collection of data regarding domestic abuse related deaths.

Bringing witnesses or consultants before the Team when necessary and appropriate for the purpose of analyzing a particular death or to gather expertise concerning domestic abuse and to subpoena all records of any nature maintained by any public or private entity that may pertain to a death being reviewed by the Team.

Interviewing victims, witnesses, family members and other close associations in a trauma informed manner with the purpose of establishing a risk timeline, identifying “red flags” and services utilized and not utilized by the victim and/or offender, and points where improved intervention services may have been helpful. Interviews of survivors and family members of a deceased victim must be done by a person with an appropriate clinical degree and experience.

Studying programs and procedures of other jurisdictions for the purpose of making recommendations for potential adoption by the Metropolitan Government.

Submitting an annual written report to the Mayor and the Metropolitan Government Office of Family Safety Advisory Committee of its activities, including any recommendations that may improve the quality or effectiveness of any program, service, or investigative technique designed to provide service and assistance to domestic abuse victims.

Making recommendations as to any new or improved legislation that would provide additional protection to domestic abuse victims and their families.

Coordinating with members of the Child Death Review Team as appropriate.

Protocol of the Team. The following procedures shall be adopted by the Team:

A Chairperson will be elected by the team. This Chairperson cannot be part of the Metropolitan Government response system to domestic violence victims. The Team's sub-chair will be the Captain of the Metropolitan Police Department Domestic Violence Division.

The Captain of the Domestic Violence Division, in coordination with the commander of the Personal Crimes Section, will, on a regular basis, (and any member on the Team may) apprise the chairperson and team members of all domestic abuse related deaths.

The chairperson will, convene Team meetings bi-monthly . In no case, however, shall meetings of the Team be conducted on less than a semi-annual basis.

The Captain of the Domestic Violence Division and the Captain of the Personal Crimes Section, subject to the parameters set forth below in subsection (10) regarding scope of review of cases, will cause all necessary reports or summaries thereof and/or investigative personnel relating to a domestic abuse death to be available to team members in a manner that preserves confidentiality.

The Captain of the Personal Crimes Section will direct all investigative personnel under his/her command to carefully analyze any suicide for a determination as to whether that suicide is in any way related to domestic abuse issues. Reports and investigative personnel relating to such a suicide will be made available to the Team.

The Team may refer the inquiry into the death of any minor child to the Child Death Review Team of the Metropolitan Government of Nashville, Davidson County, established pursuant to Tennessee Code Annotated § 68-142-101 et seq. and may cross-refer inquiries and share information related to cases involving domestic abuse within the confidentiality guidelines established under these Protocols.

The Team and other participants shall be informed at each meeting of their statutory responsibility regarding confidentiality pursuant to Tennessee Code Annotated § 36-3-624.

The Team shall exercise any subpoena authority only upon a vote of two thirds (2/3) of the voting members present and only after approval of the Team representative from the Office of the District Attorney General.

All materials or records supplied by any investigative agency or other entity to Team members shall be returned to that investigative agency or entity prior to the adjourning of a meeting. However, upon majority vote, and approval of the Team representative for the Office of the District Attorney General, one or more Team members representing an investigative component may be designated to retain such records or reports for the purpose of further review in order to provide additional information or insight to the Team members before or at the next Team meeting.

It shall be the purpose and procedure of the Team to analyze each individual domestic abuse death with a view toward developing measures that may prevent similar circumstances from resulting in a future death. It shall not be the purpose and procedure of the Team to attempt to identify liability or blame in the death being reviewed.

The Team shall take no action that may tend to interfere with the investigative process or in the prosecution of a pending criminal case and will defer to the District Attorney General for a determination of the scope of review.

The Team, when deemed appropriate, is authorized to publish recommendations that may improve the quality or effectiveness of any program, service or investigative technique designed to provide service and assistance to domestic abuse victims. Such recommendations may be in writing or presented orally. The Team shall consider publishing on an annual basis a statistical report of its activities.

The Director of Law or a designee of the Director from the Department of Law shall serve as legal advisor of the team.

ORDERED, EFFECTIVE AND ISSUED:

Megan Barry
Metropolitan County Mayor

Date: February 24, 2016

APPOINTED MEMBERS OF THE DOMESTIC ABUSE DEATH REVIEW (DADRT)

Bonnie Beneke **TN Dept of Children Services**
A representative from the Tennessee Department of Children's Services

Kimi DeMent **Legal Aid Society**
A representative from Legal Aid Society of Middle Tennessee and the Cumberlands

Tracy DeTomasi **YWCA**
A representative of a domestic violence abuse shelter and crisis hotline

Ana Escobar **District Attorney's Office**
The District Attorney General of Davidson County or designated assistant district attorney

Nichelle Foster **Metro Public Health Department**
The Director of the Metropolitan Government Department of Health or a designee

Erica Gilmore **Metro Council at Large**
The chairperson of the Health, Hospitals And Social Services Committee of the Metropolitan Council or a designee

Cathy Gurley **You have the Power**
Two representatives from non-profit groups that serve domestic violence victims

Susan Kay **Citizen**
A private citizen who has demonstrated an interest in reducing the incidence of domestic abuse

Diane Lance **Office of Family Safety**
The Department Head for the Office of Family Safety or a designee

Melanie Lutenbacher **Vanderbilt**
A representative with domestic violence expertise from the medical community

Peter Macdonald **Citizen**
A private citizen who has demonstrated an interest in reducing the incidence of domestic abuse

James (Jim) McDowell **Davidson County Sheriff's Office**
The Sheriff of the Metropolitan Government or a designee

John Pugh **Morning Star Sanctuary**
Two representatives from non-profit groups that serve domestic violence victims

Michelle Richter **Captain Metro Police DV Unit**
A representative the Domestic Violence Division of the Metropolitan Police Department

Susan Tucker-Smith **DA's Office Victim Witness**
Victim Witness Coordinator from the Davidson County District Attorney's Office

Additional individuals may be invited to attend DADRT Meetings when they had involvement working with any of the parties in the case being reviewed.

The Team is staffed by the Metro Nashville-Davidson County Office of Family Safety High Risk Programs Manager, Becky Owens Bullard.

DADRT CONFIDENTIALITY AGREEMENT

I agree to serve as a representative of the Davidson County Domestic Assault Death Review Team (DADRT) and to honor a commitment to prepare for, attend, and constructively participate in meetings of the Review Team during my tenure.

I acknowledge that the effectiveness of the review process depends on the quality of trust team members bring to it. I therefore agree that I will not use any material or information obtained during the Review Team meetings for any reason other than that for which it was intended.

I further agree to safeguard any records, reports, investigative material and information I receive from unauthorized disclosure. I will not take any case identifying material from a meeting other than that which originated in the organization I represent. I therefore will not make any copies or otherwise document/record material available in these reviews, including electronically, except for copies of departmental records I take into case review meetings for the purpose of sharing the copies of the records with the other Review Team representatives as part of the review. I understand that I must retrieve all such copies immediately following the case review. I will return all material shared by others at the end of each meeting.

I understand and acknowledge that the unauthorized disclosure of confidential records, reports, investigative materials and information may result in civil and criminal liability and removal from the Review Team.

Unless specifically authorized to do so by the chairperson and sub-chairperson wherein the chairperson and sub-chairperson sets forth the information and circumstances I may discuss, I agree to refrain from representing the views of the Review Team to the media, and understand and acknowledge that only the chairperson and sub-chairperson may represent the Review Team before the media.

DADRT Case Data Collection Tool

General Information

Panel Review Initiated: Click here to enter text.

Panel Review Concluded: Click here to enter text.

Incident Information:

Date of Death: Click here to enter text.

Case Number: Click here to enter text.

Incident Location: Click here to enter text.

Cause of Death: Click here to enter text.

Type of Murder: Single-Death ☐ Multiple Deaths ☐ Murder/Suicide ☐

Witnesses: Click here to enter text.

Substance Abuse at Death/Murder: Victim ☐ Perpetrator ☐

OP at Time of Incident ☐ Yes ☐ No **Probation/Parole at Time of Incident:** ☐ Yes ☐ No

Incident Details: Click here to enter text.

Charges/Outcome: Click here to enter text.

Incident History between Victim & Defendant

Incident Summary	Date	Outcome/Sentence
Click here to enter text.		Click here to enter text.
Click here to enter text.		Click here to enter text.
Click here to enter text.		Click here to enter text.
Unreported Incidents	**Date**	**Description**
Click here to enter text.		Click here to enter text.
Click here to enter text.		Click here to enter text.

Additional Domestic Violence Incident History for Defendant		
Incident Summary	**Date**	**Outcome/Sentence**
Click here to enter text.		Click here to enter text.
Click here to enter text.		Click here to enter text.

Additional Domestic Violence Incident History for Victim		
Incident Summary	**Date**	**Outcome/Sentence**
Click here to enter text.		Click here to enter text.
Click here to enter text.		Click here to enter text.

OP History between Victim & Defendant		
OP Number & Details	**Date**	**Outcome**
Click here to enter text.		Click here to enter text.
Click here to enter text.		Click here to enter text.

Additional OP History for Defendant		
OP Number & Details	**Date**	**Outcome**
Click here to enter text.		Click here to enter text.
Click here to enter text.		Click here to enter text.
Click here to enter text.		Click here to enter text.

Additional OP History for Victim		
OP Number & Details	**Date**	**Outcome**
Click here to enter text.		Click here to enter text.
Click here to enter text.		Click here to enter text.
Click here to enter text.		Click here to enter text.

Victim Information

Name: Click here to enter text.

Relationship with Perpetrator: Click here to enter text.

Length of Relationship with Perpetrator: Click here to enter text.

Status of Relationship at time of Death: Click here to enter text.

DOB: Click here to enter text. **Sex**: Click here to enter text. **Race**: Click here to enter text.

Primary Language: Click here to enter text. **Nationality:** Click here to enter text.

Level of Education: ☐ No High School ☐ Some High School ☐ High School Degree ☐ GED ☐ Some College ☐ Bachelor's Degree ☐ Vocational Degree ☐ Master's Degree ☐ Doctoral Degree

Employment Status at DOD: ☐ Employed-fulltime ☐ Employed-part-time ☐Unemployed ☐ Retired ☐ Stay at Home Parent ☐ On Disability ☐ Student ☐ Military ☐ Unknown

If employed, where and what type of work: Click here to enter text.

Public Assistance Programs: ☐ Food Stamps ☐ Public Housing ☐ SSI

Summary of Life History:

Click here to enter text.

Mental Health History:

Click here to enter text.

Substance Abuse History:

Click here to enter text.

Children Information

Did the Victim have any Children?: ☐ Yes ☐ No **How Many:** Click here to enter text.

Was the Victim pregnant?: ☐ Yes ☐ No

Child's Name	Age	Present during Murder?	Child of Perpetrator?
Click here to enter text.		☐ Yes ☐ No	☐ Yes ☐ No
Click here to enter text.		☐ Yes ☐ No	☐ Yes ☐ No

Were there any DCS cases with the children? ☐ Yes ☐ No ☐ Unknown

Details: Click here to enter text.

Were there any other children living in the home?: ☐ Yes ☐ No

Were any of these children present at the time of the murder? ☐ Yes ☐ No

Additional Information: Click here to enter text.

Perpetrator Information

Name: Click here to enter text. **DOB:** Click here to enter text. **OCA #** Click here to enter text.

Age: Click here to enter text. **Sex**: Click here to enter text. **Race**: Click here to enter text.

Primary Language: Click here to enter text. **Nationality:** Click here to enter text.

Level of Education: ☐ No High School ☐ Some High School ☐ High School Degree ☐ GED ☐ Some College ☐ Bachelor's Degree ☐ Vocational Degree ☐ Master's Degree ☐ Doctoral Degree

Employment Status at DOD: ☐ Employed-fulltime ☐ Employed-part-time ☐Unemployed ☐ Retired ☐ Stay at Home Parent ☐ On Disability ☐ Student ☐ Military ☐ Unknown

If employed, where and what type of work: Click here to enter text.

Public Assistance Programs: ☐ Food Stamps ☐ Public Housing ☐ SSI

Summary of Life History:

Click here to enter text.

Mental Health History:

Click here to enter text.

Substance Abuse History:

Click here to enter text.

Criminal History:

# of Reports in Year before death: Click here to enter text. **Total # of DV Reports:** Click here to enter text.

☐ In Jail ☐ Deceased ☐ On Probation/Parole

☐ Gang-involved ☐ Firearm Carrier ☐ Active OP at time of murder ☐ Sex Offender

Lethality Red Flags:

Most Concerning: Click here to enter text.

Reviewed by High Risk Intervention Panel?: ☐ Yes ☐ No

If yes, what actions were taken/recommended: Click here to enter text.

☐ Used weapon or threatened?	☐ Threaten to kill you or kids	☐ Think might try to kill you?
☐ Have gun or easy access?	☐ Choked or strangled?	☐ Jealousy/Control?
☐ Left or separated?	☐ Unemployed?	☐ Tried to commit suicide?
☐ Child that isn't his/hers?	☐Follow, Spy, Threatening?	☐ Attempted to kill before?
☐ Rape/Forced Sex?	☐ Escalating Violence?	☐ Multiple Strangulations?
☐ Violence During Pregnancy?	☐ Animal Abuse?	☐ Kidnapping/Confinement?

Agency Involvement

List any agencies that were involved with the Victim and/or the Perpetrator during the past 10 years.

Agency	Victim				Perpetrator			
	YES	NO	U/K	At Time of Incident	YES	NO	U/K	At Time of Incident
	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐

Identified Issues from Death Review

	YES	NO	U/K	Explain:
Services for Victim (access to services, availability of services, effectiveness of services, etc.)	☐	☐	☐	
Services for Perpetrator	☐	☐	☐	
Substance Abuse of Victim	☐	☐	☐	
Substance Abuse of Perpetrator	☐	☐	☐	
Investigation of Past DV Charges	☐	☐	☐	
Prosecution of Past DV Charges	☐	☐	☐	
Disposition of Past DV Charges	☐	☐	☐	
Interagency Communication/Coordination	☐	☐	☐	
Child Abuse/Neglect	☐	☐	☐	
Victim Family History of Abuse	☐	☐	☐	
Perpetrator Family History of Abuse	☐	☐	☐	
Other:				

DADRT Recommendations:

Click here to enter text.

DADRT Follow-Up:

Click here to enter text.

Metro Office *of*
Family Safety