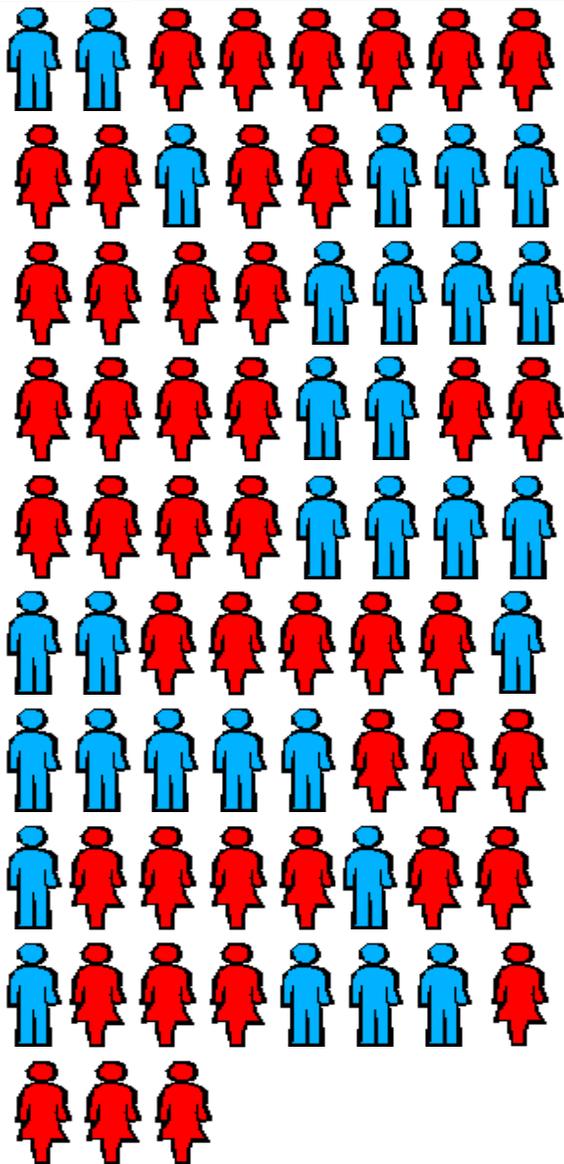


# Domestic Violence Homicide in Oklahoma



A  
REPORT  
OF  
THE  
OKLAHOMA  
DOMESTIC  
VIOLENCE  
FATALITY  
REVIEW  
BOARD  
2007

# ACKNOWLEDGEMENTS

The members of the Domestic Violence Fatality Review Board and the staff of the Oklahoma Criminal Justice Resource Center gratefully acknowledge the time and effort rendered during this project. The outcomes of this project would not have been possible without the gracious cooperation and collaboration of the officials and their staffs acknowledged here.

- Oklahoma State Bureau of Investigation
- Office of the Chief Medical Examiner
- Oklahoma Department of Human Services
- Oklahoma State Department of Health

Many thanks to all of the County Sheriffs, Police Chiefs, District Attorneys and Court Clerks and their staffs who have helped us gather the case materials. We realize many of you are already pushing the boundaries of time and we appreciate your hard work. A special thanks to the Oklahoma Violence Against Women Act Board through the Oklahoma District Attorneys Council. The S.T.O.P. Violence Against Women Act Grant funds this project. Without this support this project would not be possible.

## DOMESTIC VIOLENCE FATALITY REVIEW BOARD MEMBERS

<u>Office Represented</u>	<u>Member</u>	<u>Designee</u>
<i>Listed Directly In Statute</i>		
Chief Medical Examiner	Jeffery Gofton, M.D.	Eddie Johnson
Commissioner of the Department of Mental Health & Substance Abuse Services	Terri White, M.S.W.	Julie Young
State Commissioner of Health	James Crutcher, MD, MPH, FACPM	Sue Vaughan Settles, L.S. W. (Chair)
Director of the Criminal Justice Resource Center	K.C. Moon, Director	Carol Furr, J.D.
Chief of Injury Prevention Service, OSDH	Shelli Stephens-Stidham, MPA, Chief	Sheryll Brown, MPH
Oklahoma State Bureau of Investigation Director	DeWade Langley, Director	Jon Loffi, Division Director
Office of the Attorney General	Designee of the Victim Services Unit	Stan Florence (designee)
Oklahoma Department of Human Services	Howard H. Hendrick, Director, J.D., MBA	Susan Krug, AAG (Co-Chair)
		Tamatha Mosier (designee)
		Esther Rider-Salem, MSW
		Afton Wagner (designee)
<i>Appointed by the Attorney General of Oklahoma for two-year terms</i>		
Oklahoma Sheriffs Association	County Sheriff	Jimmie Bruner, Sheriff (7/01 – 6/07)
		Don Hewett, Sheriff
Oklahoma Association of Chiefs of Police	Chief of Police	Fred Savage, Chief
Oklahoma Bar Association	Private Attorney	G. Gail Stricklin, J.D.
District Attorneys Council	District Attorney	Tim Harris, District 14 (7/05 – 6/07)
		Jeff Smith, District 16
Oklahoma State Medical Association	Physician	Martina Jelley, M.D.
Oklahoma Osteopathic Association	Physician	Michell Cohn, D.O.
Oklahoma Nurses Association	Nurse	Janet Wilson, Ph.D., RN
Oklahoma Coalition Against Domestic Violence & Sexual Assault	Domestic Violence Survivor	Juskwa Burnett (8/03-6/07)
		Melissa Lockhart
	Citizen	Marcia Smith, OCADVSA Director
		Tim Gray, J.D., M.A., C.D.S.V.R.P. (designee)

The 75 figures on the cover of the report represent the 75 men, women and children who died as a result of domestic violence homicide in Oklahoma in 2007 that the Oklahoma Domestic Violence Fatality Review Board are aware of as of April 2008.

# DOMESTIC VIOLENCE HOMICIDE IN OKLAHOMA

January 2007-December 2007

## A REPORT OF THE OKLAHOMA DOMESTIC VIOLENCE FATALITY REVIEW BOARD 2007

### *Inside this report:*

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## A MULTI-DISCIPLINARY ANALYSIS

**I**t is the intention of the Oklahoma Domestic Violence Fatality Review Board (Board) to increase professional and public awareness of the dangers and warning signs of volatile domestic violence situations so future deaths can be prevented. The Board has reviewed a total of 216 cases since it began in 2001.

During 2007, the Board completed in-depth reviews of intimate partner domestic violence homicides and continued to educate others about what the Board has learned as a result of case reviews. This report provides

a summary of findings and presents Board recommendations for 2007.

Highlighted are the main activities of the Board this past year starting with two major collaborations. Additionally, common themes, missed opportunities and the danger warning signs or “red flags” recognized in many cases reviewed this past year are illustrated. Most importantly, the necessary systems actions to prevent further domestic violence homicides are also included.

### **Findings in Brief:**

- 56% of victims were killed by a current or former intimate partner.
- 47% of intimate partner perpetrators made death threats against the victim prior to the homicide.
- 41% of intimate partner victims were in the process of leaving the perpetrator.
- 33% of the homicides were witnessed by children.

## COLLABORATION WITH UNITED STATES ATTORNEY'S OFFICES

**F**ederal law prohibits any person who has been convicted of a misdemeanor domestic violence offense, a prior felony conviction or that has an active, qualifying protection order against them from possessing a firearm [18 U.S.C. 922 (g)(8) and 18 U.S.C. 922(g)(9)]. It is also a felony to transfer a firearm to such an individual. In 2007, 53% (41/77) of domestic violence homicide victims in Oklahoma were killed with a firearm. Of the 216 cases reviewed by the DVFRB to date, perpetrators who were legally prohibited from possessing a firearm under federal law committed 23% of the 112 firearm deaths.

To gain more understanding of the enforcement of federal firearms laws intended to protect victims of domestic violence, selected board members attended a national conference sponsored by the National Council of Juvenile and Family Court Judges, the National Center on Full Faith and Credit and Battered Women's Justice Project in partnership

with the Office on Violence Against Women, U.S. Department of Justice, as part of an Oklahoma team. Following the conference, board member Susan Krug, representing the Office of Attorney General (OAG), contacted the three U.S. Attorney Districts in Oklahoma to collaborate on an effort to enhance enforcement of the federal legislation in Oklahoma. In Spring 2007, the Eastern District U.S. Attorney's Office, the OAG, and DVFRB staff launched an eight-site collaborative training effort to help local entities navigate the federal legislation effectively. The trainings were open to local law enforcement, prosecutors, advocates and other interested members of the public. More than 200 participants attended the trainings across southeastern Oklahoma. Currently, the OAG and DVFRB staff are coordinating a similar effort with the Northern District U.S. Attorney's Office.

## COLLABORATION WITH CHILD DEATH REVIEW BOARD

**I**n January 2007, the Child Death Review Board (CDRB) and the DVFRB held a joint retreat at Quartz Mountain Lodge. The purpose of the retreat was to look at the intersection of the two boards and discuss future collaboration. The DVFRB statutory definition of domestic violence includes violence against children related to the perpetrator. As a result, the DVFRB and the CDRB do occasionally review the same case. A central topic of discussion was to explore how the boards' legislation could be modified to allow joint reviews of common cases.

To our knowledge, this is the first time such collaboration has been undertaken in the United States. Bills modifying the two boards' legislation were requested for the 2008 Legislative session and are currently making their way through the process. If legislation allows, board staff will identify common cases for an annual joint review session. Of particular interest to the boards are cases involving domestic violence between the parents as a factor in the child's death or cases involving a dating relationship between adolescents resulting in a fatality.

# FINDINGS FROM ALL IDENTIFIED DOMESTIC VIOLENCE HOMICIDES

Over the past ten years, the DVFRB has identified 776 homicides (average of 78 deaths per year) resulting from domestic violence that occurred in Oklahoma (cases tracked from 1998—2007). DVFRB staff tracks and compiles hard copy files for all identified cases. Case files are coded and data is entered into an electronic database that is used to conduct statistical analyses. The full board meets once a month to conduct extensive reviews on selected cases (approximately 9 cases per year). To date, case files have been compiled and partial data entry completed for all 776 victims. More extensive data elements were entered for the 216 cases that received full board review.

Figure 1. Victims' Cause of Death

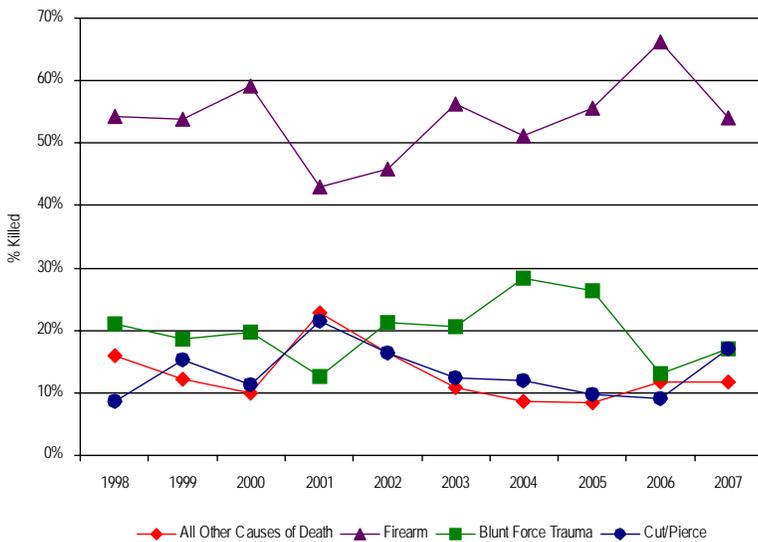
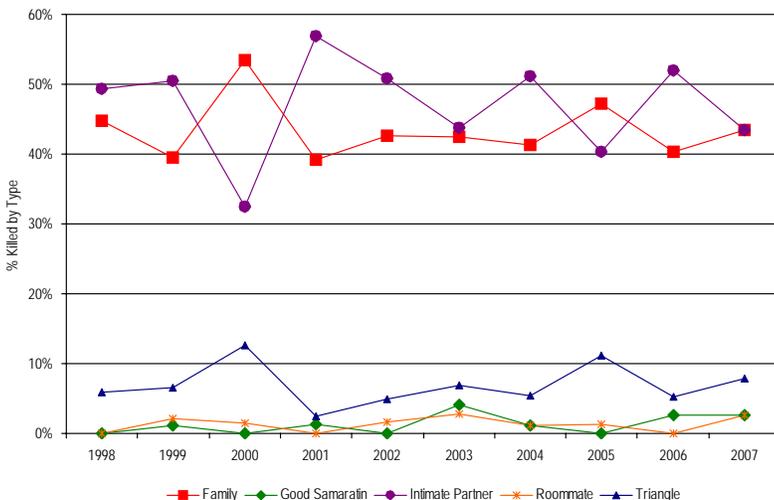


Figure 2. Type of DV Homicide Incident



Firearms were the leading method used to kill in domestic violence homicides (53%). Blunt force trauma was the second leading method used to kill (19%), followed by cutting/piercing (13%), strangulation (4%), asphyxiation (2%), undetermined (2%), and all other causes of death (6%). Figure 1 shows the causes of death for each year. Intimate partner (IP) homicides represented 48% of all of the homicides over the ten-year period the DVFRB has collected data. Family member homicides were the second largest group, representing 43% of all domestic violence homicides, followed by 7% for triangular homicides (i.e. a woman's ex-boyfriend kills her new boyfriend or vice versa). Roommates represented 1% of perpetrators and Good Samaritans (non-involved people who intervene in a domestic violence altercation on behalf of the victim) were victims in 1% of the domestic violence homicides identified by the DVFRB. Figure 2 shows the types of incidents for each year. Furthermore, 16% (126) of all homicides were the result of homicide-suicides, resulting in the deaths of 126 victims and 104 perpetrators.

*53% of domestic violence homicides are committed with a firearm*

# FINDINGS FROM REVIEWED DOMESTIC VIOLENCE HOMICIDES

As of January 2008, the DVFRB had conducted reviews on 216 domestic violence homicide incidents that occurred from 1998 to 2006. The 216 homicide incidents included 239 victims and 243 perpetrators. The findings reported below provide the basis for the Board’s annual recommendations. Table 1 provides demographic characteristics of the victims and perpetrators. The average age of victims was 33 years of age and the average age of perpetrators of domestic violence homicides was 38 years of age. The youngest victim was less than a day old; the eldest 91. The majority of victims were white (71%), followed by Black (19%) and Native American (9%). Five percent of victims were of Hispanic or Latino origin. The youngest perpetrator was 13 years of age; the eldest was 89 years of age. The majority of perpetrators were white (71%), followed by Black (21%) and Native American (8%). Six percent of perpetrators were of Hispanic or Latino origin. Overall, the majority of homicides were homogeneous; only 27 (13%) were interracial homicides.

Intimate partners were responsible for killing 56% of the victims in the reviewed cases (Figure 3). In 56% of the cases, the perpetrator and victim were cohabitating. The average relationship length between the victim and perpetrator was 15.1 years.

Figure 3. Domestic Violence Homicide by Type

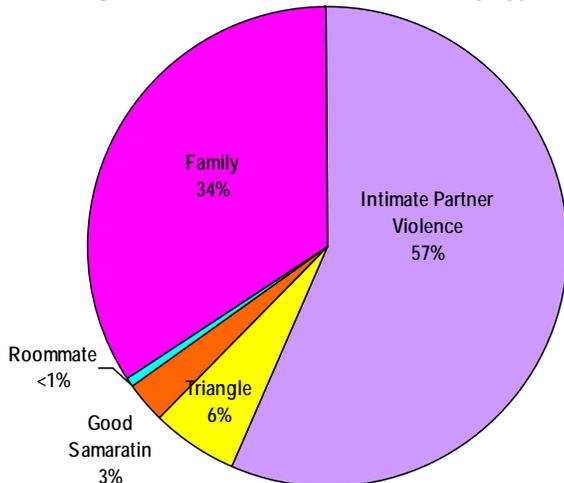


Table 1. Characteristics

	Victims		Perpetrators	
	Female (N=133)	Male (N=102)	Female (N=51)	Male (N=165)
Average Age	33.8	33.4	36.3	34.2
Median Age	33.2	33.7	38.2	33.5
Race				
White	96 72%	72 71%	39 76%	118 72%
Black	26 20%	19 19%	10 20%	31 19%
American Indian	10 8%	11 11%	2 4%	15 9%
Native Hawaiian/Pacific Islander	1 1%			1
Of Hispanic or Latino Origin	5 4%	7 7%	1 2%	10 6%

## RED FLAGS

The DVFRB also tracks the “Red Flags” of lethality. Red Flags are specific factors that indicate a high degree of dangerousness and include, victim in the process of leaving the relationship, death threats, morbid jealousy (e.g., “If I can’t have you, no one can”), attempted or threatened suicide by the victim or perpetrator prior to the death event, and step-children in the home. In 41% of the IP homicides the victim was in the process of leaving the perpetrator. In 47% of the IP cases the perpetrator had made death threats against the victim; the victim had made death threats against the perpetrator in 11% of the cases. Morbid jealousy was documented in the behavior and words of 37% of the perpetrators prior to the death event. Twenty-two percent of perpetrators of IP homicide had attempted or threatened suicide prior to the death event. In intimate partner homicides-suicide incidents, the percentage of perpetrators threatening or attempting suicide was 28%. In 29% of the homes where the intimate partners had children, there was evidence of child abuse. In nearly one-third (29%) of intimate partner homicides the perpetrator had been violent toward the victim in a public setting where others witnessed the violence. Finally, in 16% of the intimate partner homicides the perpetrator told somebody besides the victim that they were going to kill the victim. Of the homicides committed by intimate partners, 41% of the victims had children

## FINDINGS FROM REVIEWED DOMESTIC VIOLENCE HOMICIDES

with the perpetrator and 54% had children with a former partner.

### WITNESSES

There were witnesses in 56% of the cases reviewed. Adults witnessed the homicide in 44% of the incidents. The number of adult witnesses ranged from one to 18 in any of the cases. Children witnessed one-third of the slayings. In cases with child witnesses, the number of witnesses ranged from one to 30 children.

### FIREARMS

Firearms were used in 58% of the reviewed homicides. The majority of all of the homicides occurred at the victim's residence (67%), most often in bedrooms (28%) or living rooms (25%).

### PRIOR CONVICTIONS

Eighty-two percent of victims and 61% of perpetrators did not have a prior conviction record, while 79% of victims and 55% of perpetrators had never been arrested before. Of those with prior conviction records, the average number of convictions was 3 for victims; and 4 for perpetrators. Six percent of perpetrators had a prior conviction for a domestic violence offense.

### PROTECTIVE ORDERS

Orders of Protection (PO) had been utilized in 20% of the reviewed cases. In two-thirds (16/24) of the cases where a protective order was active at the time of the homicide, the defendant had violated the PO prior to the homicide. The average number of violations was 3.2 violations per order. Victims reported stalking behavior by the perpetrator to law enforcement (10), family (10), friends (9), employer (2), neighbors (1), and the court (1).

### LAW ENFORCEMENT

Law enforcement had responded to previous domestic disturbances in 28% of the cases; the

average number of responses was 2.6 documented responses per case. (This number is likely much higher since it only counts documented responses. If an officer responded, but did not complete a report, it is unaccounted for in this number.)

### OTHERS AWARE OF DOMESTIC VIOLENCE

In 59% of the reviewed cases, other people were aware that the violence was occurring. In 58 (27%) cases, more than one person or entity was aware of the violence. Persons who knew prior to the homicide that domestic violence was occurring included family members (68%), friends (56%), and law enforcement (40%).

### PROSECUTION

Charges were filed in 89% of the cases where the perpetrator did not commit suicide and convictions were attained in 88% of those cases. Six (4%) were acquitted of the charges (although they admitted to involvement in the events causing the death), three (2%) died before the completion of prosecution, in six (4%) cases the charges were dismissed, and two (1%) were found not guilty by reason of insanity. It took an average of one year and three months to complete each case from the date of death to conviction, with a range of 36 days to 4 years and 10 months.

### CONVICTIONS

Of those convicted, 79% were sentenced to prison; 12% received a split prison and probation sentence; 2% received probation only; 5% were ordered into OJA custody; 1% was sentenced to county jail and 1% received only a fine. The average sentence was 23.7 years, not including those sentenced to life or life without parole or death. Sentences ranged from 4 years to 91 years. Twenty-eight were sentenced to life in prison; 32 were sentenced to life without parole; and three were sentenced to death.

# ACTIONS NEEDED TO IMPROVE SYSTEM RESPONSE TO DOMESTIC VIOLENCE AND PREVENT HOMICIDE

## OKLAHOMA DOMESTIC VIOLENCE FATALITY REVIEW BOARD

### *Thorny Issues:*

The DVFRB should continue to 1) investigate the effectiveness of lethality instruments used by professionals for reducing homicide, and 2) educate the public and professionals about board findings including the role of firearms in domestic violence homicides. The DVFRB should utilize a speaker's bureau to accomplish this goal.

## ALL SYSTEMS

### *Thorny Issues:*

The Board has realized throughout the reviews performed that there are several areas of note that could be improved in every system that plays a role in victim safety. First and foremost the Board recommends each system develop mechanisms to prevent victims from "falling through the cracks." Secondly, domestic violence awareness and assessment should be included in the core education for all service providers. The sooner service providers are aware of the issues the more likely they are to recognize the violence, furthermore, if service providers hit the ground with the appropriate methods to approach the issue, the less likely they are to fall into the complacency we see in some areas now. The Board further recommends all service providers familiarize themselves with lethality and danger indicators. It is a rare case that occurs without any "red flags," the problem is that few recognize the red flags for what they are and what they mean to victims. Finally, the Board realizes that many agencies that provide services to victims are doing so on budgets that are already stretched to capacity. Therefore, the Board believes that the Oklahoma Legislature should make sure stable, adequate funding is appropriated to the systems providing direct services to victims of domestic violence and preventative services to perpetrators of domestic violence. Additionally, legislation and funding are needed to create and sustain prevention programs in early life before violence has occurred to promote positive youth development and healthy relationships.

### *Necessary Actions:*

- Explore the use of lethality and danger assessments for system professionals.
- Create a Speakers Bureau from DVFRB members to educate system professionals and the public about issues concerning domestic violence fatalities.

### *Necessary Actions:*

- Develop mechanisms for system accountability to ensure victims are not "falling through the cracks."
- Domestic violence awareness and assessment need to be included in the core education of counselors, attorneys, doctors, nurses, etc.
- Support inter-professional pilot studies of danger assessment tools in professional settings. Adopt appropriate, validated lethality assessments across disciplines.
- All systems need to be aware of lethality/danger indicators and how to appropriately respond to ensure victim safety.
- The Oklahoma Legislature should appropriate funding to agencies involved in direct services to victims of domestic violence and prevention/intervention services to batterers, at a level adequate to maintain at a minimum baseline services to all those seeking services.
- Communities across the state should collaborate to develop a coordinated community response to domestic violence.

# ACTIONS NEEDED TO IMPROVE SYSTEM RESPONSE TO DOMESTIC VIOLENCE AND PREVENT HOMICIDE

## DEPARTMENT OF CORRECTIONS

### *Thorny Issues:*

The DVFRB has found that in some of the cases that were reviewed, perpetrators were under the control of the Department of Corrections. To further preventative efforts of domestic violence and domestic violence homicides, the Department of Corrections should screen probationers and prisoners for domestic violence. DOC should make available referrals and programs for batterers' intervention services and victim support when necessary.

### *Necessary Action:*

- The DVFRB should engage the Department of Corrections in discussing domestic violence screening and intervention opportunities for inmates and probationers.

## COURTS

### *Thorny Issues:*

The DVFRB has found that in some of the cases that were reviewed, the court and judges could have played a critical role in preventing the domestic violence homicide. Thus, the Board recommends that the courts utilize a bench card to assist judges in recognizing red flags and potential danger when granting protective orders. Further, District Attorney's and victims' advocates are encouraged to assess the level of danger/lethality that a victim of domestic violence faces and provide that information to judges for reviewing the case. The Board recommends that judges receive continuing education on victim protective orders and bail/bond issues in domestic violence cases.

### *Necessary Actions:*

- Utilize a bench card for judges handling protective orders to assist the court in recognizing red flags and potential danger. Danger assessments should be performed and reviewed by the judge before ordering the conditions of a protective order and/or bail. Before dismissing a protection order at plaintiff's request, judges should ascertain why a petitioner is dropping a protective order, ask why it was granted in the first place and how circumstances have changed, and make sure that it is in the petitioner's best interest and safety to do so.
- Danger assessments should be performed and reviewed by the judge before ordering the conditions of bail and in situations where potential danger to the victim may be present, a no contact with the victim should be a condition of bond.
- Courts should maintain accurate and detailed records regarding protective orders, and make a good faith effort to be accessible to every victim of domestic violence.
- Safety planning information and referrals should be accessible to all victims applying for an order of protection.

# ACTIONS NEEDED TO IMPROVE SYSTEM RESPONSE TO DOMESTIC VIOLENCE AND PREVENT HOMICIDE

## DOMESTIC VIOLENCE VICTIM ADVOCATES

### *Thorny Issues:*

The DVFRB has found that in many of the cases reviewed, a history of domestic violence was present, but the victim had not accessed any domestic violence services that may have prevented the death. Also, many times family and friends knew what was happening. The Board recommends that domestic violence service providers include bystander education in their programs to help family and friends of persons suffering from abuse know what kinds of action to take. Also, the Board recommends that services strive to develop outreach programs to find victims that are “hidden,” make services accessible and acceptable in a variety of settings, and always include children in safety planning.

### *Necessary Actions:*

- Bystander education - Work with family/friends – understanding what to do when confronted with violence; awareness of violent situations, responding to threats of violence or death threats.
- Always include children in safety planning and orders of protection.
- Seek to expand services – geographic and variety.

## HUMAN & SOCIAL SERVICE PROVIDERS

### *Thorny Issues:*

The DVFRB has found that in many of the cases reviewed victims and perpetrators were clients of the Department of Human Services. Though not all were clients in the Adult or Child Protective Services areas, many were still receiving aid from the state. The Board recommends that OKDHS continue to improve its capacity to identify and make referrals for domestic violence victims that are also receiving services from the agency.

### *Necessary Actions:*

- Continue to identify and make referrals to services available for victims of domestic violence and their children.
- Continue to improve capacity of Oklahoma Department of Human Services workers to assess danger to children and other clients by including domestic violence screening and response in operating procedures. [Note: Screening and assessment of the risk factors for domestic violence requires specialized training. Further, an attempt to provide domestic violence services in the home not only holds potential danger for the home visitation staff, it particularly presents danger for victims and children, especially if conducted by staff who are not specifically trained. In addition to the training, home visitation staff should also complete an internship at a domestic violence shelter or crisis center. As an example, the Children First program operated by the Oklahoma State Department of Health requires at least 4 hours of training for their home visitation nurses that is provided twice a year by the Oklahoma Coalition Against Domestic Violence and Sexual Assault.]

# ACTIONS NEEDED TO IMPROVE SYSTEM RESPONSE TO DOMESTIC VIOLENCE AND PREVENT HOMICIDE

## HEALTH CARE

### *Thorny Issues:*

The DVFRB has found that in many of the cases reviewed the victim was seeking medical services for various ongoing ailments not necessarily resulting from domestic violence. Though medical providers saw many of the individuals, they were never screened or asked about safety or domestic violence in the home. As a result, this matter was never addressed or referred and in many cases, continued as a possible underlying contributor to the ongoing medical condition. The Board recommends medical service providers regularly screen patients for domestic violence and make appropriate referrals when necessary. Finally, all health care providers should be aware of the state requirements for reporting domestic violence.

### *Necessary Actions:*

- Health care providers should assess patients for domestic violence and when abuse is discovered assess for danger and provide specific referrals and/or interventions to reduce risk and increase safety for women, children, persons with disabilities, and elders, and document findings in the medical record.
- Health care organizations should require that providers have training in screening and assessment, and recognition of abuse in all healthcare settings including hospitals, long-term care facilities, primary care physicians, obstetric and gynecology, behavioral health units, health departments and Planned Parenthood.
- All health care professionals should become familiar with the current Oklahoma domestic violence reporting law [21 O.S. § 644].

## LEGAL

### *Thorny Issues:*

The DVFRB has found that in several of the cases reviewed victims had contact with a private attorney prior to the homicide. Often it seemed, particularly in divorce proceedings, that the peril created by the ongoing domestic violence was ignored or sacrificed in order to expedite the process, because they felt the courts might not respond openly to claims of domestic violence. This proved fatal in several cases. Domestic violence is a threat to the safety of clients, particularly when divorce and separation proceedings are occurring. Every effort should be made to maintain the safety of these clients. The Board recommends all attorneys working in divorce and family law should be trained on domestic violence regularly. The Board further recommends that laws designed to protect children and victims of domestic violence in family courts in matters of custody and visitation should be established and expanded.

### *Necessary Actions:*

- Training/Education on representing adult and child victims of family violence:
  - ♦ Target all attorneys who work in divorce, family, and juvenile law through law school and offer continuing legal education credits.
- Establish/expand laws designed to protect children and victims of violence in family courts in matters of custody and visitation.

# ACTIONS NEEDED TO IMPROVE SYSTEM RESPONSE TO DOMESTIC VIOLENCE AND PREVENT HOMICIDE

## LAW ENFORCEMENT

### *Thorny Issues:*

The DVFRB has found that in nearly one-third of the cases reviewed, law enforcement had prior contact with the victim and perpetrator regarding domestic violence. As this is a point of intervention, the Board recommends law enforcement agencies adopt the practice of evidence-based prosecution for misdemeanor and felony domestic violence as the standard in their community. The Board further recommends officers and Deputies work with local domestic violence advocates to make sure victims get the necessary support. Law enforcement should perform danger assessments on all domestic violence calls. This will help officers understand the dynamics of the situation that might not be readily apparent. Finally, law enforcement should always provide victims of domestic violence, sexual assault and stalking with Safeline cards.

### *Necessary Actions:*

- Cooperate with District Attorneys to implement evidence-based prosecution to overcome the situation when a victim is uncooperative or wants to drop charges. Effective scene investigation and documentation including a record of behavior, excited utterances, and a location description and completing a detailed report.
- Law enforcement should work with domestic violence advocates to make sure victims of domestic violence receive follow-up contact.
- Develop the capacity to perform Danger/Lethality Assessments on all domestic violence calls – with particular attention to weapon accessibility & presence.
- Always provide a Safeline card to the victim of domestic violence, sexual assault or stalking.
- Always notify OKDHS of children on the scene at domestic violence disturbance calls.

## DISTRICT ATTORNEYS

### *Thorny Issues:*

The DVFRB has found that in some of the cases reviewed, District Attorneys' Offices could have played a critical role in preventing the domestic violence homicide. To potentially prevent domestic violence homicides, the Board recommends that each District Attorney's Office adopt evidence-based prosecution as usual practice for prosecuting cases of domestic violence. This includes working with law enforcement to collect and preserve evidence to overcome the situation when a victim is uncooperative or wants to drop charges. Additionally, training in evidence-based prosecution is recommended.

### *Necessary Actions:*

- Implement evidence-based prosecution to overcome the situation when a victim is uncooperative or wants to drop charges. Seek law enforcement's cooperation in collecting, preserving and organizing evidence for use in domestic violence cases.
- Provide Evidence-Based Prosecution and Domestic Violence 101 Training to all District Attorneys and Assistant District Attorneys that prosecute domestic violence.

# ACTIONS NEEDED TO IMPROVE SYSTEM RESPONSE TO DOMESTIC VIOLENCE AND PREVENT HOMICIDE

## MENTAL HEALTH & SUBSTANCE ABUSE PROVIDERS

### *Thorny Issues:*

The DVFRB has found that in some of the cases reviewed the victim and/or perpetrator had contact with mental health and/or substance abuse providers. There were still more cases where those services were needed, but not readily available to the victim or perpetrator. The emergency order of detention (EOD) process appears to be problematic, particularly when individuals are released before a victim has time to prepare or engage a safety plan. The Board recommends that mental health services should be more accessible to more Oklahomans. The Board further recommends that all mental health and substance abuse workers receive training on domestic violence and danger assessment, and that standardized assessments regarding violence be implemented universally. Finally, lethality/danger risk assessments need to be included in the emergency order of detention assessment and release process for persons with a history of interpersonal violence.

### *Necessary Actions:*

- Funding should be made available to make mental health care more accessible to more Oklahomans.
- Mandate training in domestic violence and danger assessment for all mental health and substance abuse workers/professionals. Implement standardized assessments for violence, including domestic violence (perpetration and victimization) and provide appropriate referral and care.
- Review emergency order of detention (EOD) assessment and release process. Incorporate lethality/danger risk assessments and rigid criteria for release when persons with a history of interpersonal violence who are held under an EOD.

## EDUCATION

### *Thorny Issues:*

Unfortunately, the DVFRB has reviewed cases where teenagers and young adults were killed as primary or secondary victims in intimate partner violence related homicides. The Board recommends that prevention of intimate partner violence begin by educating young children and adolescents, especially those at high risk for partner violence because of exposure to domestic violence, to recognize dating/relationship violence and help them to achieve healthy relationships in adult life. To some degree this can be accomplished with school-based violence prevention curriculum.

### *Necessary Action:*

- Implement evidence-based prevention programs/curricula for children and adolescents (K-12 grade) that target dating violence and abuse, and promote healthy relationships.

# BOARD ACTIVITIES

## PRESENTATIONS/TRAINING

- The DVFRB partnered with the Eastern District U.S. Attorney's Office and the Oklahoma Office of Attorney General to conduct eight trainings on the federal firearm restrictions.
- Tamatha Mosier, Sue Settles, Gail Stricklin, and Brandi Woods-Littlejohn presented at the Area II, III and IV Judicial Conference.
- Tamatha Mosier and Brandi Woods-Littlejohn presented on lethality and safety planning at the Oklahoma Sheriffs' Association Conference and at the Oklahoma Highway Patrol training academy.
- Sue Settles and Brandi Woods-Littlejohn presented on lethality and safety planning at the August 2007 Indian Health Service Behavioral Health Conference in Tulsa.
- Janet Wilson presented DVFRB findings at Veteran Affairs Medical Center, February 2007: Mental Health Response to IPV.
- Janet Wilson presented DVFRB findings to OUHSC Consortium.
- Brandi Woods-Littlejohn presented on the DVFRB in five classes in the Crime Victim and Survivor Services division at Oklahoma State University-Oklahoma City.
- Susan Krug and the Office of Attorney General:
  - Supported the Domestic & Sexual Violence Partnership Conference;
  - Supported regional domestic violence trainings;
  - Sent 6 people to national Office of Violence Against Women training;
  - Cut-it-out Training (domestic violence awareness training for cosmetologist);
  - Presented training on "Lethal Domestic Violence, Protective Orders and Surrendering of Firearms" at the Annual Judicial Conference;
  - Presented training on Federal Firearm Restrictions and VINE Protective Order at the Annual Sheriffs Association Conference.

## OTHER ACTIVITIES

- Oklahoma Nurses Association Intimate Partner Violence Task Force (formed by Board member Janet Wilson in 2005) meets regularly.
- ONA IPV task force developed an American Nurses Association IPV Resolution to be presented at the 2008 ANA national convention. Data from the Oklahoma DVFRB will be presented as well as national data, to illustrate why Oklahoma is spearheading professional change in this area. ONA President, Karen Tomajan, will present the resolution at the convention. The resolution advocates:
  - ♦ Awareness of magnitude of problem of IPV and health care providers often as first responder
  - ♦ Promotion of routine, universal, and culturally sensitive screening, interventions, and documentation of IPV
  - ♦ Promotion, facilitation of use of Campbell Danger Assessment
  - ♦ Collaboration with the American Academy of Nurses (AAN) Expert Panel on Violence and National Institute of Nursing Research (NINR) for increased research funding for intimate partner violence
  - ♦ Convening a task force comprised of IPV nurse researchers and experts to update ANA's 2000 Position Statement on Violence Against Women
  - ♦ Development of ANA action plans for intimate partner violence education and training for nurses in the area of IPV.
- ONA/OUHCN partnership to develop IPV online continuing education module for RNs, which include DVFRB findings.
- Janet Wilson and Sheryll Brown developed a research proposal using Campbell's danger assessment tool to test the use of a modified danger assessment in law enforcement.
- ONA newsletter regularly publishes the DVFRB annual report, conferences, etc.
- ONA IPV task force is going to partner with the Oklahoma Hospital Association to disseminate information more widely to hospitals.
- Judge Mark Campbell has informed other judges and local prosecutors about the importance of carefully reviewing each case

## BOARD ACTIVITIES

where “Caitlin’s Law,” a law reversing the burden of proof requiring a defendant to prove they are not a safety risk for bond in kidnapping cases, might apply.

- ODMHSAS has established 9 mobile child crisis teams and regional child crisis centers covering 19 counties and three regional child crisis centers (Woodward, Oklahoma City, and Tulsa). These teams will be important to following up with children on the scene after a homicide has occurred.
- Office of Attorney General:
  - ◆ Capital Dome Lighting (which raises awareness of Domestic Violence);
  - ◆ Began implementation of the VINE Protective Order OVW grant;
  - ◆ Partnered with Wal-Mart to promote Safeline number access.
- In 2007, the Oklahoma Coalition Against Domestic Violence and Sexual Assault:
  - ◆ Supported a DVFRB recommendation by focusing on “bystanders” including friends, family and co-workers;
  - ◆ Secured funding to hire a graphic artist and a writer to assist in developing a friends and family series of booklets. The booklet will be available in hard copy and for download from the OCADVSA website;
  - ◆ ‘Recognize, Respond, Refer’ - Focused many presentations on bystander/friend and family/co-worker response;
  - ◆ OCADVSA focused on responding to victims with disabilities including working toward developing a coalition to address violence against women with disabilities, brochures and cross training domestic violence and disability advocates;
  - ◆ OCADVSA made a PSA campaign part of their strategic plan;
  - ◆ Data from the DVFRB is utilized and cited in all statistical presentations, this is especially effective when discussing the impacts of domestic violence on children;
  - ◆ In support of the 2006 recommendation to 'be aware of options under VAWA and VOCA' –Marcia Smith trains at each OCADVSA Certified Domestic and Sexual Violence Response Professional (CDSVRP) training on Full Faith and Credit, and discusses safe and appropriate response to immigrant victims. Response to immigrant victims is addressed in many of the OCADVSA training sessions;
  - ◆ The ‘Safety Planning’ training offered for OAG Certification Standards includes safety planning with children.

**OKLAHOMA DOMESTIC VIOLENCE FATALITY  
REVIEW BOARD**

3812 N. Santa Fe, Suite 290  
Oklahoma City, OK 73118-8500

Phone: 405-524-5900  
Fax: 405-524-2792  
Email: bwoodslittlejohn@ocjrc.net

**Available on the Web!**  
**[www.ocjrc.net/dvfrb](http://www.ocjrc.net/dvfrb)**

Please go to <http://www.ocjrc.net/> to review:

- This report
- Enabling Legislation
- The DVFRB Mission, Purpose and Definitions
- Methods and Limitations of data collection and data
- History of the Board

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Written by: Brandi Woods-Littlejohn, MCJ,  
Project Director

If you or someone you know needs help in a Domestic Violence situation, please call:

**Safeline – 1-800-522-SAFE (7233)**

If you need general information about Domestic Violence, please call:  
Oklahoma Coalition Against Domestic Violence and Sexual Assault – (405) 524-0700  
The Office of the Attorney General, Victim Services Unit – (405) 521-3921

If you need more information about the Oklahoma Domestic Violence Fatality Review Board, please call:  
Oklahoma Criminal Justice Resource Center – (405) 524-5900

**If you are in an emergency situation please dial 911  
immediately.**

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