Philadelphia Women's Death Review Team

Analysis of Deaths Among Philadelphia Women Ages 15 through 60

2002 and 2003

Including a Review of Trends, 1997--2003

A project of the Philadelphia Department of Public Health, The Philadelphia District Attorney's Office, Women in Transition and the Philadelphia Health Management Corporation

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Chapter 1. Executive Summary

I. Introduction and Background

Violence against women is a critical public health problem that has devastating physical and emotional consequences for women and their children. The Philadelphia Women's Death Review Team (PWDRT) is the first multi–agency, multi–disciplinary effort in Philadelphia County designed to prevent future violence related deaths to women. The Team does this by:

(1) Tracking the incidence and prevalence of violence-related deaths of women;
(2) Identifying the degree to which intimate partner violence (IPV) contributes to the community's mortality;
(3) Identifying patterns and trends in violence-related deaths of women; and
(4) Formulating key policy and practice recommendations to improve the systems that serve and protect women and their children.

PWDRT employs a public health model to identify deaths where there is evidence of a history of violence in the lives of women who die. Such a model includes the screening of all deaths, regardless of manner, of Philadelphia women ages 15 to 60. All cases that meet any of the following criteria are then selected for full case review:

- Homicide
- Suicide
- Undetermined cause
- Drug or alcohol-related natural death (e.g., cirrhosis of the liver)
- AIDS or HIV-related disease (e.g., atypical mycobacterium)
- Death due to adverse drug reactions
- Death to a woman within a year of giving birth (pregnancy-associated)
- Death with questionable circumstances
- Inadequate death certificate

Team members meet monthly to review and share information regarding these cases. As a result of the death review process, participating agencies obtain a more complete understanding of the circumstances that surround women's deaths in Philadelphia, and are better equipped to design informed strategies to reduce the number of violence-related deaths among Philadelphia women.

This report includes PWDRT's most recent data from 2002 and 2003, as well as 1997-2003 aggregate data since PWDRT's inception. This report is grouped into chapters and, when appropriate, the most recent data (data from 2002 and 2003) is discussed first. Data trends from 1997 to 2003 are then examined, summarizing data beginning from the Team's inception. PWDRT has reviewed the deaths of 711 women dying in 2002 and 2003; and reviewed 2,630 women in the years 1997 to 2003. PWDRT has reviewed 26 percent of all deaths to Philadelphia women ages 15 to 60 between 1997 and 2003[1].

[1] The Philadelphia electronic City File calculates that 10,086 Philadelphia women between 15 and 60 have died between 1997 and 2003.

II. Definitions

Domestic Violence (DV) consists of behaviors, physical, sexual, emotional, used in any relationship to gain or maintain control (National Domestic Violence Hotline, 2005b). Domestic violence includes not only violence in intimate partner relationships of spousal, live-in partners and dating relationships, but also includes familial, elder and child abuse present in a home (National Coalition Against Domestic Violence, 2005).

Intimate Partner Violence (IPV) refers to violence, often repeated, that happens between current or former spouses or paramours. The partners may be married or not married, homosexual or heterosexual, living together or separately, separated, or dating (CDC, 2004b).[2]

Protection From Abuse Orders (PFA) are issued by Philadelphia Family Court, and direct the defendant/abuser to refrain from abusing, threatening, harassing, or stalking the plaintiff; to stay away from the plaintiff's home (even if it is also the defendant's residence), work, or school; and to turn weapons over to the police. PFAs can be issued for up to 18 months, and are available to anyone abused by a current or former spouse, a parent, a child, a current or former sexual or intimate partner (including both heterosexual and homosexual partners), and others related by blood or marriage (Women's Law Project, 2005).

[2] There is no one agreed upon definition of Domestic Violence or Intimate Partner Violence. These terms are often used interchangeably.

III. Data Highlights: 2002 and 2003

Homicide

- Between 2002 and 2003, 75 Philadelphia women died as a result of a homicide.
- Twenty (27%) of the homicide victims had a known history of domestic violence.

Intimate Partner Violence Deaths

- Thirty women (n=30) are known to have died directly as a result of IPV in Philadelphia between 2002 and 2003. In Philadelphia during these years, intimate partner homicide accounts for 40 percent of all homicides to women ages 15 to 60.

Gun-Related Deaths

- Between 2002 and 2003, 55 deaths reviewed by PWDRT were gun-related (including 35 homicides and 20 suicides). Gun-related deaths represent 8 percent of violence-associated deaths reviewed by PWDRT in 2002 and 2003.

Drug and/or Alcohol-Related Deaths

- Forty percent (n=281) of the violence associated deaths of Philadelphia women between 2002 and 2003 were related to drugs and/or alcohol.
- The majority of these women (64%, n=181) had a know substance abuse history.
- Fifteen percent (n=42) of these women had a known history of domestic violence.

AIDS/HIV Related Deaths

- PWDRT reviewed 158 HIV/AIDS related deaths (22%) to Philadelphia women that occurred between 2002 and 2003.
- Fifteen percent of these women (n=24) had a known history of domestic violence.

Commercial Sex Work

- Ten percent (n=68) of the decedents reviewed between 2002 and 2003 had a history of commercial sex work or prostitution.
- Twenty-one percent of these women (n=14) had a known history of domestic violence.

Homelessness

- Sixty-one women (9%) reviewed between 2002 and 2003 were either currently homeless or had a history of homelessness prior to their deaths.
- Eight of these women were homeless at the time of their death.
- One-quarter of women with a history of homelessness (26%, n=16) had a known history of domestic violence.

Deaths Among Immigrant Women

- PWDRT reviewed 32 women who died between 2002 and 2003 who were born outside of the United States.
- One of these women (3%) had a known history of domestic or intimate partner violence in their lives.

Mental Health

- One hundred ninety-six decedents (28%) who died between 2002 and 2003 had a history of diagnosis and/or treatment for a mental health condition.
- Twenty-one percent of these women (n=41) had a known history of domestic violence.

Children

- Between 2002 and 2003, at least 465 children, under the age of 18, lost their mother to a violence-associated death.
- At least 21 children directly witnessed the death of their mother or found her body between 2002 and 2003.

IV. Data Highlights: 1997-2003

Homicide

- Between 1997 and 2003, 275 Philadelphia women died as a result of a homicide. The rate of homicide to Philadelphia women was highest most recently in 2003 at 8.0 deaths per 100,000 women.
- More than one in four homicide victims had a known history of domestic violence (28%, n=78).

Intimate Partner Violence Deaths

- One hundred ten women (n=110) are known to have died directly as a result of IPV in Philadelphia between 1997 and 2003. In Philadelphia during these years, intimate partner homicide accounts for 40 percent of all homicides to women ages 15 to 60.
- The rate of intimate partner homicide has declined since 1997 (at 4.6 deaths per 100,000 women) with the lowest rates in 2000. In 2003 (at 3.1 deaths per 100,000) rates were 33 percent lower than in 1997, the time of the Team's inception.

Gun-Related Deaths

- Between 1997 and 2003, 187 deaths reviewed by PWDRT were gun-related (including 145 homicides, 40 suicides and 2 undetermined deaths). Gun-related deaths represent 7 percent of violence-associated deaths reviewed by PWDRT since 1997.

Drug and/or Alcohol-Related Deaths

- Forty one percent (n=1,068) of the violence associated deaths of Philadelphia women between 1997 and 2003 were related to drugs and/or alcohol.
- Of these women, 46 percent (n=501) had a known history of substance abuse.
- Nine percent (n=94) of these women had a known history of domestic violence.

AIDS/HIV Related Deaths

- PWDRT reviewed 549 HIV/AIDS related deaths (21%) among Philadelphia women occurring between 1997 and 2003.
- Eight percent of these women (n=42) had a known history of domestic violence.

Commercial Sex Work

- Ten percent (n=275) of the decedents reviewed between 1997 and 2003 had a history of commercial sex work or prostitution.
- Eleven percent of these women (n=31) had a known history of domestic violence.

Homelessness

- One hundred fifteen women reviewed by PWDRT were either currently homeless or had a history of homelessness prior to their deaths.
- Thirty women reviewed between 1997 and 2003 were homeless at the time of their death.

- Eighteen percent of women with a history of homelessness (n=21) had a known history of domestic violence.

Deaths Among Immigrant Women

- PWDRT reviewed 67 women who died between 1997 and 2003 who were born outside of the United States.
- Eleven of these women (16%) had a known history of domestic violence in their lives.

Mental Health

- Five hundred one decedents (19%) ever reviewed by PWDRT had a history of diagnosis and/or treatment for a mental health condition.
- Eighteen percent of these women (n=92) had a known history of domestic violence.

Pregnancy-Associated Deaths

- Between 1997 and 2003, 90 women reviewed by PWDRT died either while pregnant, or within a year of giving birth.
- Eleven percent of these women (n=10) had a known history of domestic violence.

Children

- Between 1997 and 2003, at least 1,535 children, under the age of 18, lost their mother to a violence-associated death.
- At least 32 children directly witnessed the death of their mother or found her body between 2001 and 2003.

V. Key Recommendations

PWDRT has identified six key recommendations out of the many that appear in this report (please see the Policy Recommendations chapter for more information, page 77). The Team believes these six recommendations represent the greatest need and have the most potential to reduce trauma and premature death for women and children in Philadelphia. However, please keep in mind that *each* recommendation in this report is relevant to violence in the lives of women and their children and our ability as a community to prevent violence. PWDRT's key recommendations are:

- Develop citywide domestic violence prevention efforts under the leadership of the Mayor that encourage neighbor-to-neighbor networking to reduce isolation and promote community vitality (i.e., Safer Streets – Safer Homes).

- Promote the availability of domestic violence counselors from the advocacy community to be co-located at the PFA filing unit of the Philadelphia Family Court to routinely provide safety planning, information and support to all individuals petitioning the court for protection from abuse and to provide follow-up and outreach services for those whose cases are dismissed through failure to prosecute.

- Increase the availability of intervention services for abusers by engaging those service providers already working with this population (Menergy, Men's Resource Center) to develop partnerships or additional resources through linkages with community groups (Men United for a Better Philadelphia and fatherhood initiatives) and city agencies such as men's drug treatment centers, mental health providers and prison programs.

- Develop and support a comprehensive citywide weapons-related injury surveillance system (WRISS) to capture all weapons-related injuries (i.e., guns, knives, bats, fists).

- Expand the Behavioral Health Training and Education Network (BHTEN) efforts for professional training in the mental health, child welfare, education, health, homelessness and public housing systems regarding the impact of trauma and domestic violence on women and its relationship to drugs and alcohol.

- Develop a protocol within the Police Department to automatically refer all children who have experienced the death of a parent or witnessed a traumatic event to trauma assistance services.

Chapter 2. Introduction and Methodology

I. Introduction

Violence against women represents a critical public health problem that continues to have devastating consequences for women, their children, and their families, as well as the communities in which they reside. Intimate partner violence[3] is primarily a crime against women, as documented by the following national statistics:

- "Nearly 5.3 million intimate partner victimizations occur among US women, ages 18 and older, each year. This violence results in nearly 2.0 million injuries and nearly 1,300 deaths" (CDC, 2004a).

- In 2003 Rennison reported that, "The National Crime Victimization Survey found that 85% of intimate partner violence victims were women" (CDC, 2005).

- In 2003, The Bureau of Justice Statistics reported that an average of more than three women are murdered by their husbands or boyfriends everyday (National Domestic Violence Hotline, 2005a).

- In 2001, The Federal Bureau of Investigation estimated that nearly one-third of female homicide victims reported to the police are killed by an intimate partner (CDC, 2004b).

Research suggests that efforts to reduce the amount of violence against women in our communities must focus on prevention (Crowell and Burgess, 1996). In the United States, research infrastructure to support those prevention efforts has been built in the form of fatality reviews. There are currently twenty-eight states that review and analyze deaths due to intimate partner violence, the circumstances leading to the deaths, breaches in service delivery, and then use this information to improve prevention strategies (Websdale, 2003). Toward this end, the Philadelphia Women's Death Review Team (PWDRT) represents the first multi–agency, interdisciplinary effort in Philadelphia County designed to prevent future, violence–related deaths to Philadelphia women between the ages of 15 and 60.

[3] Intimate Partner violence refers to the pattern of violent and abusive behaviors inflicted by spouses, ex-spouses, boyfriends and girlfriends, and ex-boyfriends and ex-girlfriends.

Unlike other domestic violence fatality review teams in the United States, PWDRT looks beyond intimate partner homicides in its assessment of violence against women to include other violence-associated causes of death. This choice stems from the belief that murder is not the only potentially lethal consequence of intimate partner violence. Substance abuse, HIV/AIDS, homelessness and suicide are frequently associated with violent lives (Websdale, 2003). Examining multiple factors associated with violence can assist our understanding of violence against women, its prevention and opportunities for intervention (CDC, 2005). PWDRT, therefore, examines not only homicides, but also all other cases of premature death to women in Philadelphia County in which the cause or manner of death is known to have an association with violence. By taking this broader perspective, PWDRT hopes to develop prevention strategies that address not only women at risk of homicide, but also those struggling with the associated problems of substance abuse, HIV/AIDS, homelessness and mental health disorders.

The actual review of violence-associated deaths occurs through a three-step process-- (1) review of individual deaths, (2) analysis of aggregate data, and (3) the development of recommendations for corrective and proactive action.

The four central objectives of the Philadelphia Women's Death Review Team are:

(1) To track the incidence and prevalence of violence-related deaths of women;

(2) To identify the degree to which intimate partner violence (IPV) contributes to the community's premature mortality;

(3) To identify patterns and trends in violence-related deaths of women; and

(4) To formulate key policy and practice recommendations to improve the systems that serve and protect women and their children.

PWDRT represents a collaboration of public and private agencies led by the Philadelphia Department of Public Health, Philadelphia District Attorney's Office, Women In Transition, and Philadelphia Health Management Corporation (PHMC). The Team includes representatives from government agencies, law enforcement, courts, hospitals, domestic violence service and advocacy groups, and other community agencies. Since the Team's inception in 1997 many agencies have contributed to the PWDRT data gathering process. These member agencies are critical partners in all that PWDRT does.

Member agencies reviewing 2002 and 2003 deaths include:

- Anti–Violence Partnership of Philadelphia
  - Families of Murder Victims
- Children's Crisis Treatment Center
  - Trauma Assistance Program
- Congreso de Latinos Unidos, Inc.
- District Attorney's Office
- Drexel University School of Public Health
- Federal Bureau of Investigation
- Lutheran Settlement House
  - Bilingual Domestic Violence Project
- Office of Emergency Shelter and Services
- Medical Examiner's Office
  - Grief Assistance Program, Inc.
- Philadelphia Department of Behavioral Health/Mental Retardation Services
  - Community Behavioral Health
  - Office of Mental Health
- Philadelphia Courts
  - Adult Probation and Parole Department
  - Family Court Division – Domestic Violence Unit
- Philadelphia Department of Human Services
  - Children and Youth Division
- Philadelphia Department of Public Health
  - The Division of Maternal, Child and Family Health
- Philadelphia Health Management Corporation
  - Research and Evaluation
- Philadelphia Legal Assistance
- Philadelphia Police Department
  - Homicide Unit
  - Special Victims Unit
- Temple University School of Medicine
- Women Against Abuse
- Women In Transition
- Women Organized Against Rape
- Women's Law Project

II. Methodology

The Philadelphia Women's Death Review Team is comprised of four interdependent components: **Core Leadership Committee**, **Clinical Screening Committee**, **Review Team**, and **Policy Committee**. Each component is responsible for a specific aspect of collecting, sharing, and discussing information regarding any history of reported violence or other factors known about a woman's death which may indicate that domestic or intimate partner violence was a factor in her life.

PWDRT reviews deaths of women aged 15 to 60 years who were residents of Philadelphia County at the time of their deaths. Deaths are identified through the following three sources:

1) Death Certificate (Appendix D) information is provided by the Division of Information and Reimbursement Systems of the Philadelphia Department of Public Health in the form of paper death certificates and a compact disk with the Electronic City File of deaths[4];
2) Medical Examiner Files located at the Philadelphia Office of the Medical Examiner; and
3) Review of media reports.

Death certificate data are stored in a secure database and in a locked file located at PHMC. All deaths are reviewed retrospectively, approximately one year after the date of death. This method of retrospective review allows PWDRT to obtain the most complete information available and usually ensures that active investigations and open cases within the criminal justice system are complete by the time of PWDRT review.

Team Composition and Activities

Team leadership is provided by the Core Leadership Committee, which includes designated representatives from the Philadelphia Department of Public Health, Philadelphia District Attorney's Office, Women In Transition, and Philadelphia Health Management Corporation (PHMC). The Core Leadership Committee meets monthly to oversee the direction of PWDRT, set the agenda, determine Team membership, and monitor project activities including program development and fiscal management.

The Clinical Screening Committee is comprised of representatives from public health, human services, medicine, law enforcement, and victim's services, and meets monthly at the Medical Examiner's Office to review all death certificates of Philadelphia female residents ages 15 to 60. This committee examines the death certificates for adequacy of information, and determines which cases should be forwarded to the Review Team for a further review.

[4] The City gets death certificate information from the Pennsylvania State Division of Health Statistics. The data on the disk are the primary source of death certificate information. We use the City certificates for filing, to fill in missing data in the fatality database housed at PHMC, and to bring to the monthly review meetings. We use the State certificates only when we are missing a paper City certificate.

Between 1997 and 2003, all deaths falling into one or more of the following categories were selected for further review:

(1) homicide[5],
(2) suicide,
(3) undetermined manner of death[6],
(4) drug or alcohol-related natural death (e.g., cirrhosis of the liver),
(5) AIDS or HIV-related disease (e.g., atypical mycobacterium),
(6) death due to adverse drug reactions,
(7) death to women known to be within a year of giving birth or pregnant at time of death (pregnancy-related),
(8) death with questionable circumstances, and
(9) inadequate death certificate

Based on the work of this committee, a list of cases to be reviewed is distributed to members of the Review Team two weeks before the monthly review meeting, thus allowing Team members time to collect case-specific information from their agencies.

The Review Team meets monthly in a confidential and collaborative forum to systematically review deaths selected by the Clinical Screening Committee. Team members include individuals from government, non-government and community agencies working in the areas of law, health, advocacy and social service (Appendix A). Representatives from the participating agencies share confidential information regarding any agency contact and/or interaction with the women or their children prior to their deaths. This information also includes the completeness of the death investigation by the appropriate agencies, and, in cases of homicide, the response of the law enforcement and judicial communities. Also, when available, information is collected about the perpetrator(s) involved in the homicide cases. Each case is then carefully reviewed to identify what role, if any, domestic or intimate partner violence played in the life and death of each woman. In cases where there was a known history of violence, and in cases where an intimate partner murdered the decedent, the Review Team identifies the policies, laws, regulations, system changes, and/or services that, if implemented, might have prevented the deaths of these women. The Team uses the data and the experience of its members to formulate key policy and practice recommendations with the long-term goal of improving the systems that serve and protect women and their children.

The Policy Committee meets quarterly to continue discussions about issues that arise during monthly case review meetings, to review domestic violence policies and death prevention strategies, and, as appropriate, to create subcommittees that work to refine PWDRT's recommendations. Additionally, the Policy Committee examines issues

[5] Unlike the Uniform Crime Report's definition of "murder" (the unlawful killing of a human being with malice afterthought), "homicide" is defined as any death by the hands of another, regardless of whether charges are brought (e.g. self-defense) but does not include vehicular manslaughter.
[6] Deaths are certified as undetermined when serious doubt exists as to the cause and manner of death. Information concerning the circumstances may be lacking because of insufficient background information, lack of witnesses, or because of a lengthy delay between death and discovery of the body. If an extensive investigation and autopsy cannot clarify the circumstances, the death is placed in this category.

related to the coordination of local violence intervention and treatment systems. All PWDRT members are invited to participate in Policy Committee meetings. Invitations are further extended to elected representatives, academic institutions, agency administrators, and community advocacy groups.

Confidentiality

The review process undertaken by PWDRT requires the sharing of confidential case information. Accordingly, PWDRT has implemented measures to protect the privacy of the study population as well as the work of the Review Team participants. All Team members are required to sign a confidentiality statement prior to participating in the review process (Appendix B). Continued participation is contingent upon compliance with the terms of the confidentiality statement. The confidentiality statement prohibits unauthorized dissemination of information beyond the purpose of review, and prohibits PWDRT members from creating any files with specific case identifying information. Outside of review meetings, only aggregate PWDRT data is shared.

Data Collection and Data Management

The information that is shared at both the Clinical Screening Committee meetings and the Review Team meetings is recorded on a data form that was developed by PWDRT (Appendix C). PWDRT collects data on the victim's contact with agencies and the circumstances surrounding the death as well as information on her children and/or the perpetrator when applicable. PHMC staff enters information into a secure, computerized database located at PHMC. The original data forms are kept in a secure, locked file cabinet at all times.

Data forms are periodically adjusted to reflect new or refined variables of interest and changes in data collection methods among the agencies of Team members. Because of this, not all variables are available from 1997 to 2003. In this report we will use current variables whenever possible, and examine these data as far back as they are available.

Description of the Population

According to the 2000 Census, Philadelphia had a population of 1.52 million people. This number includes 493,969 women between the ages of 15 and 60. From 2002 to 2005, the Clinical Screening Committee reviewed all deaths of Philadelphia women between 15 and 60 years that occurred in 2002 and 2003 (N=2,878). Based on the selection criteria previously described, PWDRT selected 711 of the 2,878 deaths for full review (Table 1). The other deaths were not considered to be violence-associated.

All but four of the 2002 and 2003 deaths (n=711) selected for review were residents of Philadelphia County according to their death certificates or the City File. Four women were selected for review because the Clinical Screening Committee and the Review Team determined that they were residents of Philadelphia, although this was not recorded on their death certificates. Residency was discussed at the Review meeting, and if a

woman lived unofficially with a relative or partner in Philadelphia (not on a lease or public record, but spent most or all of her time at the residence), she was included in review.

Table 1: Deaths of Philadelphia Women (Ages 15-60) by Manner of Death and Reason for Review, 2002 and 2003

Manner of Death and Reason For Review	Number of Deaths[7]	Deaths Selected for Review***
Natural	**2,451**	**367**
AIDS/HIV		151
Long-term D/A Abuse		96
Adverse Effects of Drugs		17
Questionable Circumstances		30
Pregnancy-Associated		21
Other		54
Unintentional Injury	**244**	**177**
AIDS/HIV		5
Adverse Effects of Drugs		147
Questionable Circumstances		15
*Long-term D/A Abuse**		13
Other		14
Homicide	**73**	**75**
Suicide	**58**	**57**
Undetermined Cause	**52**	**34**
AIDS/HIV		1
Long-term D/A Abuse		3
Adverse Effects of Drugs		13
Questionable Circumstances		14
Pregnancy-Associated		2
Other		8
TOTAL	**2,878**	**711***

*One death was of unknown manner.

***Note that reasons for review may sum to a total greater that the number of cases reviewed as a case might have been selected for multiple reasons.

Source: Philadelphia Electronic City File 2002 and 2003, Philadelphia Department of Public Health and PWDRT data

This report also summarizes findings and trend data, as well as geographic data from seven years of PWDRT data, 1997 to 2003 (Appendix G, Map 2). PWDRT has reviewed the deaths of 2,630 Philadelphia women dying during this time period (Table 2).

[7] This column contains data from the electronic City File.

Table 2: PWDRT Reviewed Deaths of Philadelphia Women (Ages 15-60) by Manner of Death, 1997-2003[8]

	Manner of Death (N)						
	Natural	**Unintentional Injury**	**Suicide**	**Homicide**	**Undetermined**	**Unknown***	**TOTAL by year**
Year							
1997	211	121	30	47	21	0	**430**
1998	148	81	29	48	4	3	**313**
1999	218	77	21	35	16	0	**367**
2000	208	124	29	35	13	7	**416**
2001	191	123	30	35	10	4	**393**
2002	211	101	28	31	21	1	**393**
2003	156	76	29	44	13	0	**318**
TOTAL	**1343**	**703**	**196**	**275**	**98**	**15**	**2630**

*Twelve cases have manners of death recorded as Pending and 3 manners of death are unknown.
Source: PWDRT data

Missing Data

When reviewing deaths, some data are missing because information is not available to Team members or information cannot be accessed. It is common for women who have had an episode(s) of violence in their lives to have never come in contact with health, social, or law enforcement agencies. There are many reasons why a woman would remain unknown to these agencies, including fear, lack of knowledge or access, shame, and depression. Because of this, PWDRT is unable to have complete data on all the cases reviewed due to the under-reporting of violence in general and, specifically, in the lives of those who die. It is most likely that the incidence of violence in the lives of Philadelphia women who die prematurely described here is underreported.

[8] All but 20 of the 1997 to 2003 deaths (n=2,630) selected for review were residents of Philadelphia County according to their death certificates or the City File. Twenty women were selected for review because the Clinical Screening Committee and the Review Team determined that they were residents of Philadelphia, although this was not recorded on their death certificates.

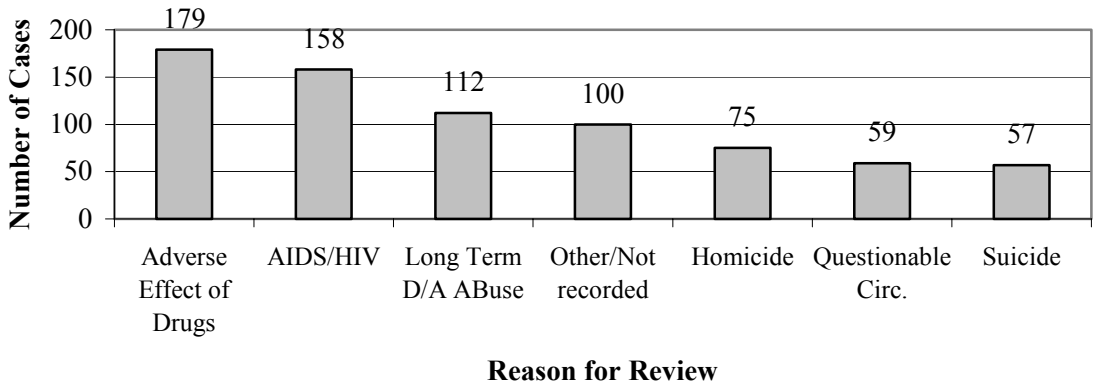
Chapter 3. Domestic and Intimate Partner Violence

I. Violence-Related Deaths in Philadelphia

Violence-Related Deaths in Philadelphia, 2002 and 2003

PWDRT reviews those deaths of Philadelphia women in which the cause of death is known to be associated with violence, as well as all deaths that the Clinical Screening Committee has determined have questionable circumstances. Figure 1 shows the breakdown of 2002 and 2003 deaths reviewed by PWDRT by the reason for review.

Figure 1: Number of WDRT Cases by Reason for Review, 2002 and 2003



Source: PWDRT data, n=711. Cases may be selected for review for multiple reasons.

Between 2002 and 2003, 105 women PWDRT reviewed (15%) had a known history of domestic violence. Between 2002 and 2003, 55 deaths reviewed by PWDRT were gun-related (including 35 homicides and 20 suicides). Gun-related deaths represent eight percent of violence-associated deaths reviewed by PWDRT in 2002 and 2003.

Violence-Related Deaths in Philadelphia, 1997- 2003

PWDRT has reviewed 26 percent of all deaths to Philadelphia women ages 15 to 60 between 1997 and 2003[9] (Appendix G). Overall death rates are displayed in Map 1. Of the 2,630 women reviewed between 1997 and 2003 (Appendix G, Map 2), ten percent (n=265) had a known history of domestic violence. Between 1997 and 2003, 187 deaths reviewed by PWDRT were gun-related (including 145 homicides, 40 suicides and 2 undetermined deaths). Gun-related deaths represent seven percent of violence-associated deaths reviewed by PWDRT since 1997.

Several Philadelphia neighborhoods (and zip codes) stand out as having the highest rate of violence-related deaths to Philadelphia women over the seven-year period of 1997-2003.

Violence-Related Deaths in Philadelphia by Neighborhood, 1997-2003

Neighborhoods (and zip codes) that experienced 130 or more violence-related deaths to women between 1997 and 2003 include (Appendix G, Map 2):

- Juniata/Feltonville (19124)
- Strawberry Mansion (19132)
- Kensington/Port Richmond (19134)
- Hunting Park/Tioga/Nicetown (19140)
- Kingsessing/Cedar Park/Cobbs Creek (19143)

Neighborhoods (and zip codes) that experienced more than 8 homicides per 100,000 women between 1997 and 2003 include (Appendix G, Map 5):

- Center City/Old City/Washington Square (19106)
- Mount Airy (19119)
- Juniata/Feltonville (19124)
- Fairmount (19130)
- Kensington/Port Richmond (19134)
- Tacony/Wissioming (19135)
- Frankford (19149)

Neighborhoods that experienced the highest number of gun-related deaths to women between 1997 and 2003 include (Appendix G, Map 7):

- With 10 deaths to women each:
  - Kensington/Fairhill (19133)
  - Kingsessing/Cedar Park/Cobbs Creek (19143)
  - Germantown (19144)
- With 9 deaths to women:
  - Strawberry Mansion (19132)

[9] The Philadelphia electronic City File calculates that 10,086 Philadelphia women between 15 and 60 have died between 1997 and 2003.

II. Domestic and Intimate Partner Violence

Definitions

Domestic Violence (DV) consists of behaviors, physical, sexual, emotional, used in any relationship to gain or maintain control (National Domestic Violence Hotline, 2005b). Domestic violence includes not only violence in intimate partner relationships of spousal, live-in partners and dating relationships, but also includes familial, elder and child abuse present in a home (National Coalition Against Domestic Violence, 2005).

Intimate Partner Violence (IPV) refers to violence, often repeated, that happens between current or former spouses or paramours. The partners may be married or not married, homosexual or heterosexual, living together or separately, separated, or dating (CDC, 2004b).[10]

Protection From Abuse Orders (PFA) are issued by Philadelphia Family Court, and direct the defendant/abuser to refrain from abusing, threatening, harassing, or stalking the plaintiff; to stay away from the plaintiff's home (even if it is also the defendant's residence), work, or school; and to turn weapons over to the police. PFAs can be issued for up to 18 months, and are available to anyone abused by a current or former spouse, a parent, a child, a current or former sexual or intimate partner (including both heterosexual and homosexual partners), and others related by blood or marriage (Women's Law Project, 2005).

Women with a personal history of DV and/or IPV often display risk behaviors that can negatively impact their physical, mental, and social health (e.g., suicidal ideation and attempts, or abuse of drugs and/or alcohol). Untreated trauma can set the stage for many potentially lethal behaviors. Victims of DV or IPV can also be restricted by their abuser from accessing social and health services, which can result in negative health and/or employment (loss of productivity) consequences.

PWDRT began collecting DV and IPV information at the inception of the Team in 1997. Trend analysis of decedents with a history of domestic or intimate partner victimization shows that such violence was present in the lives of women across all manners of death (Table 3 and Figure 2), race (Figure 3), and ethnicity (Figure 4). Trend analysis of PWDRT data also indicates improved PWDRT collection of DV/IPV reporting beginning in 2001, whereby numbers of known DV and IPV victims are noticeably higher in 2001 than in any of the first four years of data collection.

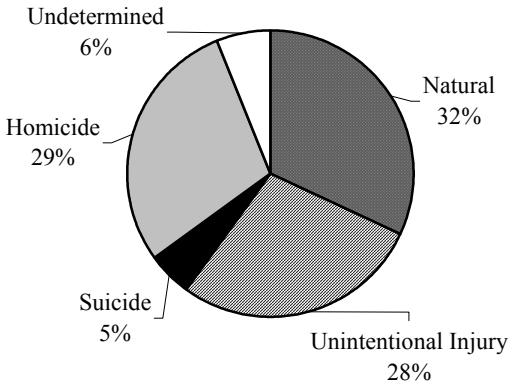
[10] There is no one agreed upon definition of Domestic Violence or Intimate Partner Violence. These terms are often used interchangeably.

Table 3: Number and Percent of Philadelphia Women (Ages 15-60) with a History of DV or IPV, by Manner of Death, 1997-2003

	1997 n (%)	1998 n (%)	1999 n (%)	2000 n (%)	2001 n (%)	2002 n (%)	2003 n (%)	TOTAL n (%)
Natural	5 (26%)	2 (16%)	2 (11%)	5 (17%)	27 (33%)	26 (42%)	17 (40%)	84 (32%)
Unintentional Injury	1 (5%)	1 (8%)	2 (11%)	10 (35%)	31 (38%)	19 (31%)	11 (26%)	75 (28%)
Suicide	1 (5%)	0 (0%)	0 (0%)	1 (3%)	6 (7%)	4 (7%)	1 (2%)	13 (5%)
Homicide	10 (53%)	9 (75%)	15 (79%)	10 (35%)	14 (17%)	9 (15%)	11 (26%)	78 (30%)
Undetermined	2 (11%)	0 (0%)	0 (0%)	3 (10%)	3 (4%)	4 (6%)	3 (7%)	15 (6%)
TOTAL n	*19*	*12*	*19*	*29*	*81*	*62*	*43*	*265*

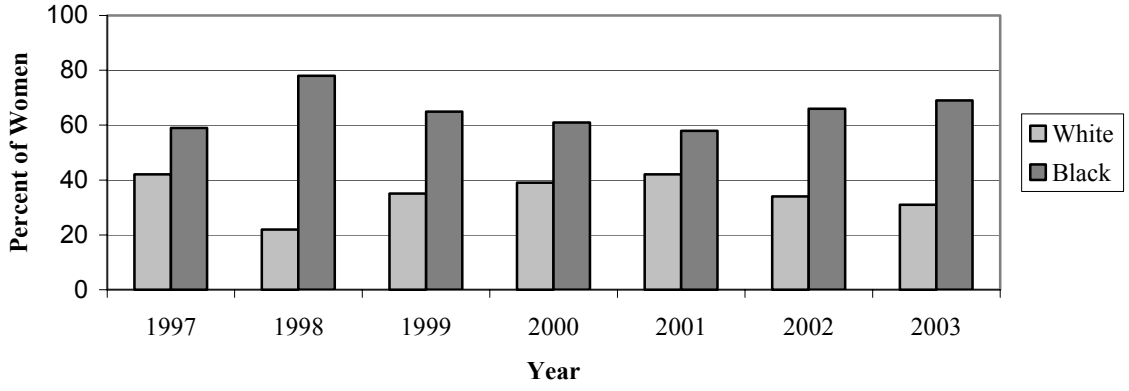
Source: PWDRT data, n=265

Figure 2: Total Philadelphia Women (Ages 15-60) with a History of DV or IPV, by Manner of Death, 1997-2003



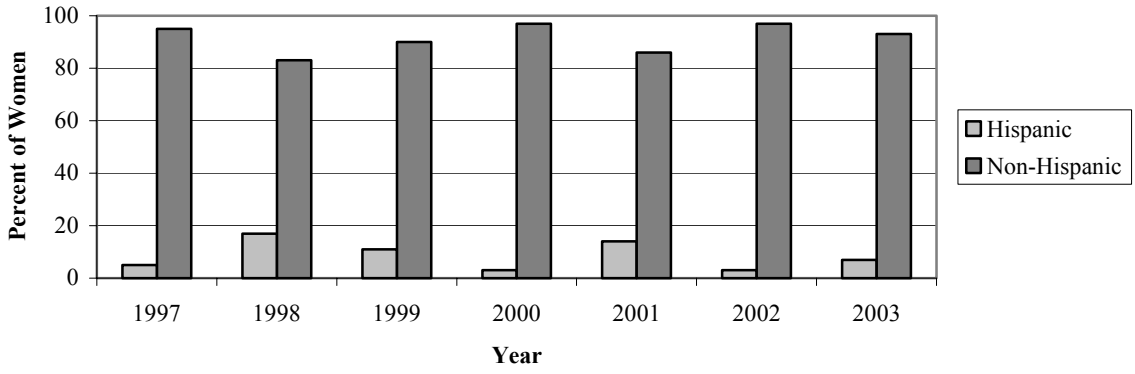
Source: PWDRT data, n=265

Figure 3: Philadelphia Women (Ages 15-60) with a History of DV or IPV, by Race, 1997-2003



Source: PWDRT data, n=265. Only women of Black or White Race included in this analysis. Percents therefore are valid percents, totaling each year to 100%.

Figure 4: Philadelphia Women (Ages 15-60) with a History of DV or IPV, by Ethnicity, 1997-2003



Source: PWDRT data, n=265. Only women of Hispanic or Non-Hispanic reported ethnicity included in this analysis. Percents therefore are valid percents, totaling each year to 100%.

Women with a history of Domestic or Intimate Partner Violence

Using indicators determined by a breadth of DV/IPV literature (CDC, 2005; Crandall et al, 2004; Brookoff et al, 1997) for identifying women most at risk for victimization in domestic violence and/or intimate partner violence, the following paragraph outlines the Team's findings about these known risk factors for violence.

Between 1997 and 2003, a total of 265 women reviewed by PWDRT were identified as having a known history as a victim of either DV or IPV. Below are some characteristics of these Philadelphia women:

- Black (60%, n=159)
- Non-Hispanic (91%, n=240)
- Age 38 (mean average)
- High School graduate (68%, n=156)
- Unemployed (89%, n=237)
- Homeless at some point in the past (8%, n=21)

Personal and family histories included:

- Substance Abuse (49%, n=129)
- Criminal History (42%, n=110)
- Diagnosis or Treatment for a Mental Health Condition (35%, n=92)
- Personal history of sexual abuse as a child (5%, n=13)
- Personal history of abuse or neglect as a child (5%, n=13)
- Perpetrator of child abuse or neglect (9%, n=25)
- Family history of child abuse or neglect, or child sexual abuse (8%, n=20)
- Family history of a perpetrator of child abuse or neglect (3%, n=7)

Through future study of behavioral and social risk factors, we might better be equipped to identify women at greatest risk for abuse, as well as identify protective factors for women (CDC, 2005).

Information about perpetrators of DV or IPV is known to the Team only in cases of homicide. Please see the following section on Intimate Partner Homicide for further information on perpetrator characteristics.

III. Intimate Partner Homicides

Intimate partner homicides are a priority for PWDRT to identify and review as a beginning point in documenting violence in the lives of Philadelphia women who die. PWDRT reviews all homicide deaths to Philadelphia women ages 15 to 60.

Research has shown that the rate of intimate partner violence (IPV) in society and the effects it has on a community's overall mortality and morbidity are staggering. A recent National Institute of Justice survey indicates that nearly 25 percent of women surveyed said that they had been raped and/or physically assaulted by a current or former spouse, cohabiting partner or date at some point in their lifetime; 7.6 percent of men had been similarly victimized (Tjaden and Thoennes, 2000). Nationwide, IPV results in nearly 2 million injuries and 1,300 deaths every year (CDC, 2005).

While both men and women are victims of IPV, literature has shown that women tend to be more frequent victims of physical injury from IPV than men, and men are tend to be more frequent perpetrators of IPV than women (Durose et al, 2005). In Pennsylvania, the Pennsylvania Coalition Against Domestic Violence notes 187 domestic violence homicides between 1997 and 2003 (personal communication, February 6, 2006); domestic violence homicides include homicides of women, men and children.

National data shows that between 1998 and 2002, of the approximately "3.5 million violent crimes committed against family members, 49% were crimes against spouses." In addition, "Females were 84% of spouse abuse victims and 86% of victims of abuse at the hands of a boyfriend or girlfriend" (Durose et al, 2005).

Because of the prevalence of IPV in society, PWDRT is particularly interested in the role IPV plays in the premature deaths of Philadelphia women. The Team aims to prevent IPV-related deaths by learning about the personal histories of the victim and the offender to better understand the relationship and events that lead up to the homicide.

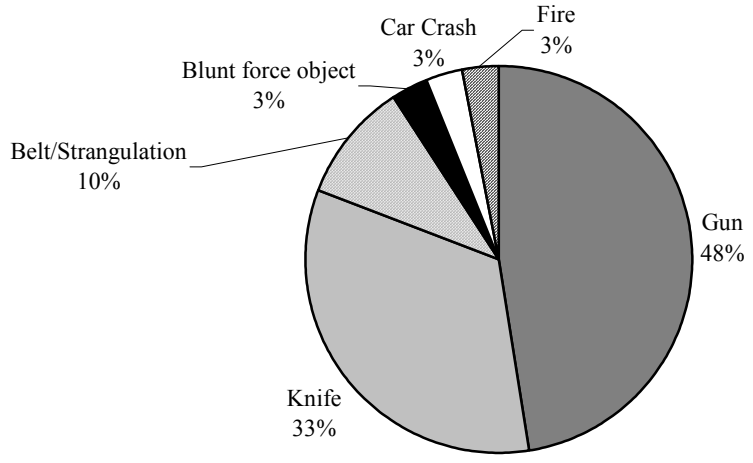
Intimate Partner Homicides, 2002 and 2003

PWDRT identified and reviewed 30 intimate partner homicides in 2002 and 2003. These were cases in which the perpetrator was the decedent's spouse/paramour or the decedent's ex-spouse/ex-paramour. Two of the IPV homicides involved 2 perpetrators. In the majority of cases of the intimate partner homicides (77%, n=23), the perpetrator was the decedents spouse/paramour and in 5 cases the perpetrators were the decedent's ex-spouse/ex-paramour. Circumstances in the remaining two IPV cases were more complicated. In one, the perpetrator was the decedent's father, who had been molesting her, and who killed both the decedent and her mother; the Team decided to classify this death as an IPV homicide. In the second case, IPV was suspected but prosecution of the suspect was not yet complete.

Women reviewed by PWDRT who were killed by an intimate partner ranged in age from 16 to 59, with a mean age of 32. The majority of these women were black (73%, n=22).

The majority of intimate partner homicides took place in the decedent's home (43%, n=19). Other places of events included the street (n=6), another residence (n=3) or unknown locations (n=2). In half of the cases of intimate partner homicides the decedent was killed using a gun (47%, n=14). Other weapons/methods included knives, strangulation, blunt force objects, a car crash and arson (Figure 5).

Figure 5: Weapon Use in IPV Homicides of Philadelphia Women (Ages 15-60), 2002 and 2003



Source: PWDRT data, n=30

After committing the homicide, ten perpetrators committed suicide, and one perpetrator attempted suicide. At the time of this analysis, information was available on three of the perpetrator's court cases: one case had been tried and the perpetrator had received a life sentence, and two other cases had been tried, although the sentence was unknown to PWDRT.

PWDRT found that five (17%) of the victims were known to have a history of mental health problems. One-quarter of the victims were known to have a history of substance abuse (27%, n=8). In addition, nine (30%) of the victims were known by the criminal courts.

Of the 30 intimate partner homicide cases reviewed by PWDRT, four (13%) women were known to have a made prior reports of domestic violence to the police department.

A total of 11 of the 30 intimate partner homicide decedents were known to family court prior to their death. Three decedents obtained final Protection From Abuse orders.

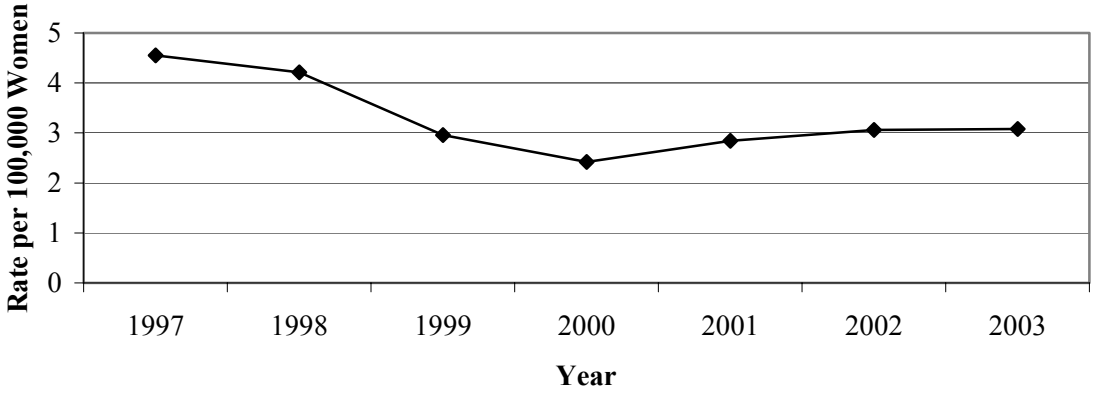
Of the 30 intimate partner homicide cases reviewed, 18 (60%) had contact with at least one of the service system agencies on the Team. Thirteen women had contact with two or more agencies, and seven women were "high-end users," having contact with three or more agencies.

In addition to contact with family court, criminal court and the police department, some decedents were also in contact with other agencies. The Department of Health's Health Centers had contact with 4 decedents, as did CBH. Other agency contacts included the Women Against Abuse hotline, Women in Transition, Women Organized Against Rape, Community Legal Services, OESS, CBH, and the Health Department

Intimate Partner Homicides, 1997-2003

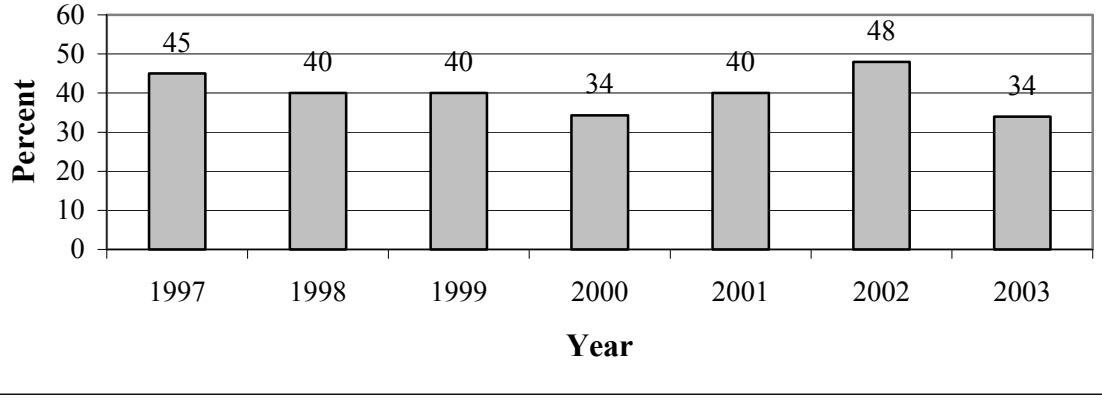
Over one hundred women (n=110) were killed between 1997 and 2003 due to IPV. Intimate partner homicides accounted for 40 percent of all homicides between 1997 and 2003. The number and rates of intimate partner homicides of women in Philadelphia have declined between 1997 and 2003 (Figures 6 and 7). The rate of intimate partner homicides in 2003, 3.1 per 100,000 women, is 33 percent lower than in 1997 (4.6 per 100,000 women). Locations of IPV homicides, 1997-2003, are mapped in Appendix G, Map 6.

Figure 6: Trends in IPV Homicide Rates Among Philadelphia Women (Ages 15-60), 1997-2003



Source: PWDRT data, n=110

Figure 7: Percent of Homicides to Philadelphia Women (Ages 15-60) that were IPV-Related, 1997-2003

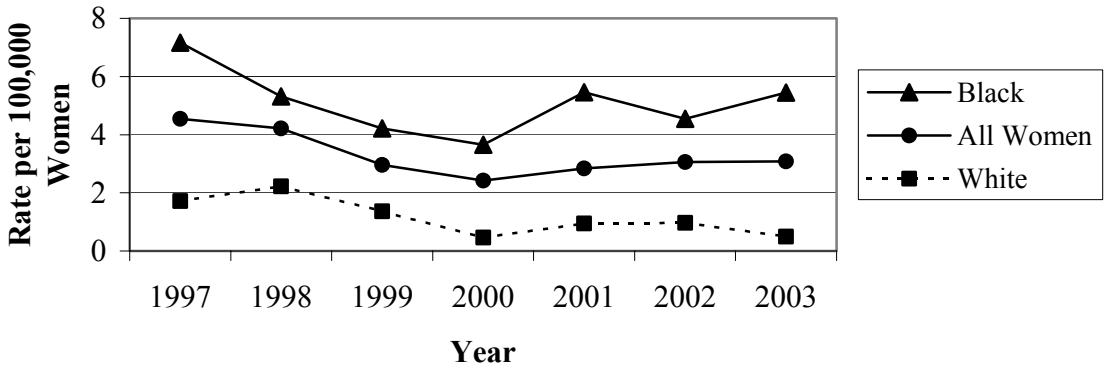


Source: PWDRT data, n=110

The overall decrease in the number and rate of IPV homicides over the last seven years in Philadelphia is differentially reflected across racial and ethnic groups. Figures 8 and 9 show the trends in the rates of IPV homicide among Black and White women, as well as Hispanic and Non-Hispanic between 1997 and 2003.

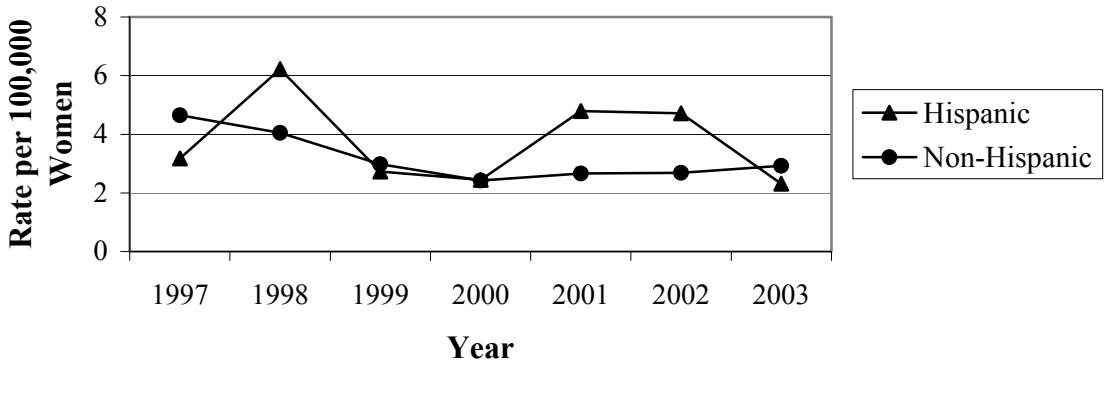
In each of the seven years, the IPV homicide rate among Black women in Philadelphia has been higher than that of White women. Hispanic women have historically died from IPV homicide at a higher rate than Non-Hispanic women in Philadelphia.

Figure 8: Trends in IPV Homicide Rates Among Philadelphia Women (Ages 15-60) by Race, 1997-2003



Source: PWDRT data, n=110

Figure 9: Trends in IPV Homicide Rates Among Philadelphia Women (Ages 15-60) by Ethnicity, 1997-2003



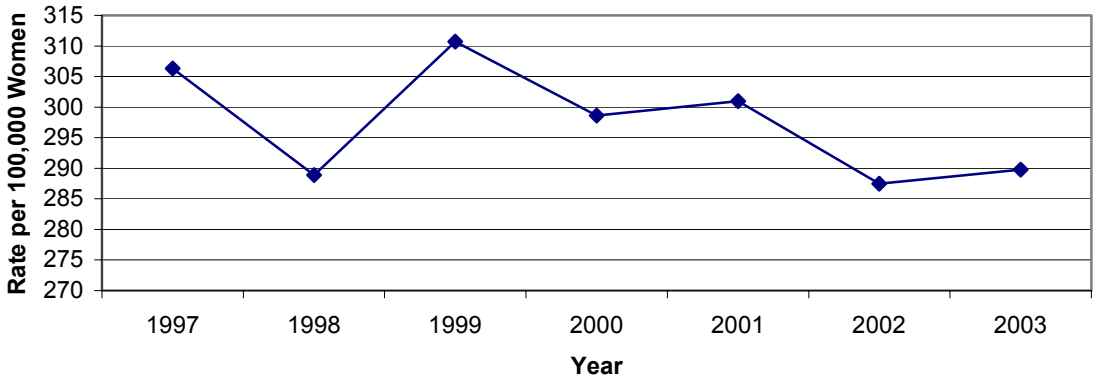
Source: PWDRT data, n=110

Chapter 4. Data Findings and Trends by Manner of Death

I. Overall Death Rates Among Philadelphia Women, 1997-2003

Between 1997 and 2003, 10,086 Philadelphia women age 15-60 died (Appendix G, Map 1). Figure 10 shows the variation in the death rate since the inception of PWDRT. A clearer trend may become more apparent as PWDRT continues to collect data.

Figure 10: Trends in Death Rates Among Philadelphia Women (Age 15-60), 1997-2003



Source: Philadelphia Vital Statistics 1997-2003, Philadelphia Department of Public Health, n=10,086

II. Deaths Among All Philadelphia Women, 2002 and 2003

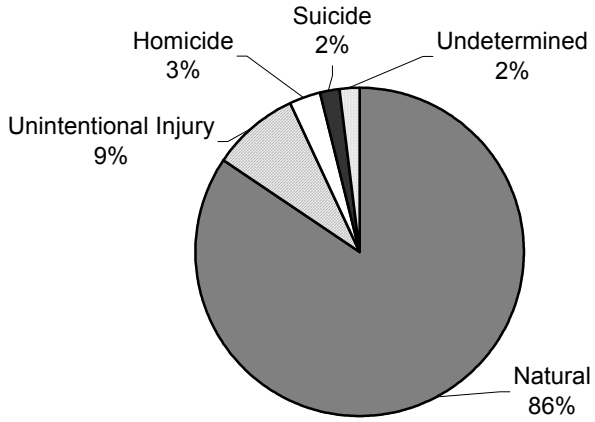
This section will present data from 2002 and 2003 death certificates provided by the Philadelphia Department of Public Health to examine the entire population of women age 15-60 who died in Philadelphia in 2002 and 2003.

2,932 Philadelphia women age 15-60 died in 2002 (n=1,467) and 2003 (n=1,465). The 2002 death rate for this age group is 287.5 per 100,000 women, and the 2003 death rate for this age group is 289.8 per 100,000 women.

Manner of Death, 2002 and 2003

Of these 2,932[11] deaths, natural causes accounted for 86 percent (n=2,450), unintentional injuries accounted for nine percent (n=244), with homicide and suicide accounting for three percent (n=73) and two percent (n=58) each, and two percent (n=52) of deaths classified as undetermined (Figure 11).

Figure 11: Manner of Death Among Philadelphia Women (Ages 15-60), 2002 and 2003*



Source: Philadelphia Electronic City File 2002 and 2003, Philadelphia Department of Public Health, n=2,877

*Manner of Death was unavailable at the time the Electronic City Files were released for 2002 and 2003 deaths in 76 cases.

Race and Ethnicity

In reporting information about race and ethnicity, PWDRT uses race and ethnicity categories provided on the death certificates: race defined as Black, White, American Indian, and other; ethnicity categorized as either Hispanic or non-Hispanic.

There is a noticeable disparity in the death rate among Black women, who constitute 59 percent of all deaths, yet made up only 45 percent of the population of Philadelphia women ages 15-60 in 2002 and 2003 (Table 4). Asian women also have a disproportionately high number of deaths; Asian women account for nearly six percent of all deaths to women 15-60 years in Philadelphia, though they constitute just 2 percent of the population in 2002 and 2003.

[11] Manner of death was unknown or pending at the time the Electronic City Files of 2002 and 2003 deaths were released in 76 cases; percentages are therefore calculated based on the 2,856 deaths for which manner of death was known. Percentages may not add to 100% due to rounding of decimals places.

Table 4: Demographic Profile of Deaths to Philadelphia Women (Ages 15-60) by Manner of Death, 2002 and 2003

Age	All Deaths*	Natural	Unintentional Injuries	Homicide	Suicide	Undetermined
15-19	38 (1%)	11 (1%)	12 (5%)	9 (12%)	2 (3%)	2 (6%)
20-24	63 (2%)	28 (1%)	17 (7%)	7 (10%)	4 (7%)	4 (13%)
25-29	88 (3%)	53 (2%)	16 (7%)	12 (16%)	3 (5%)	2 (6%)
30-34	131 (4%)	93 (4%)	20 (8%)	12 (16%)	3 (5%)	0 (0%)
35-39	234 (8%)	151 (6%)	46 (19%)	12 (16%)	10 (17%)	5 (16%)
40-44	397 (14%)	321 (13%)	47 (19%)	6 (8%)	8 (14%)	4 (13%)
45-49	491 (17%)	421 (17%)	41 (17%)	5 (7%)	8 (14%)	7 (23%)
50-54	612 (21%)	539 (22%)	35 (14%)	6 (8%)	16 (28%)	4 (13%)
55-60	878 (30%)	833 (34%)	10 (4%)	4 (5%)	4 (7%)	3 (10%)
Race						
Black	1,732 (59%)	1,504 (61%)	115 (47%)	47 (64%)	15 (26%)	15 (48%)
White	1,146 (39%)	905 (37%)	127 (52%)	21 (29%)	42 (72%)	14 (45%)
Asian	26 (1%)	20 (1%)	1 (1%)	3 (4%)	0 (0%)	2 (6%)
Other/Unknown	28 (1%)	21 (1%)	1 (1%)	2 (3%)	1 (2%)	0
Ethnicity						
Hispanic	187 (6%)	143 (6%)	18 (7%)	10 (14%)	6 (10%)	2 (6%)
Non-Hispanic	2,743 (94%)	2,306 (94%)	226 (93%)	63 (86%)	52 (90%)	29 (94%)
Unknown	2 (1%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)	0
Total	2,932	2,450	244	73	58	31

Source: Philadelphia Electronic City File 2002 and 2003, Philadelphia Department of Public Health
*In 2002, the manner of death was unknown in 36 cases and pending in two cases at the time of the city file release. In 2003, an additional 35 cases had no manner of death listed, and three were pending at the time of the city file release. Percentages may not total 100% due to rounding.

III. Natural Deaths

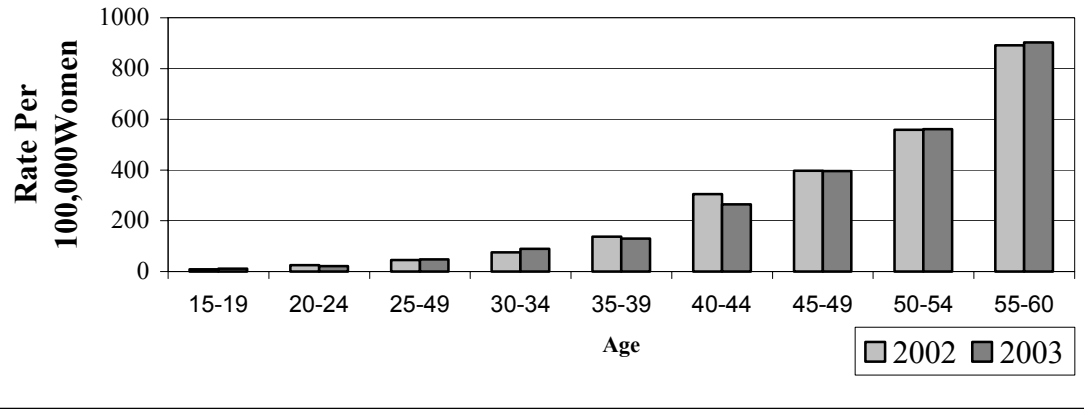
Natural Deaths, 2002 and 2003

The deaths of one in two Philadelphia women that PWDRT reviewed in 2002 and 2003 were natural deaths (52%, n=367). According to City File data, 86 percent of deaths among Philadelphia women ages 15-60 in 2002 were due to natural causes (n=1226). In 2003, natural deaths accounted for 85 percent of deaths among Philadelphia women in this age group (n=1224).

The natural death rate for Philadelphia women ages 15 to 60 was 250.7 per 100,000 in 2002 and 251.6 per 100,000 in 2003. This rate varies among Philadelphia women by age, race and ethnicity.

The death rate due to natural causes increases with ages, reflecting deaths due to disease and chronic conditions. Women ages 55 to 60 have the highest natural death rate (891.1 per 100,000 in 2002 and 903.2 per 100,000 in 2003) (Figure 12).

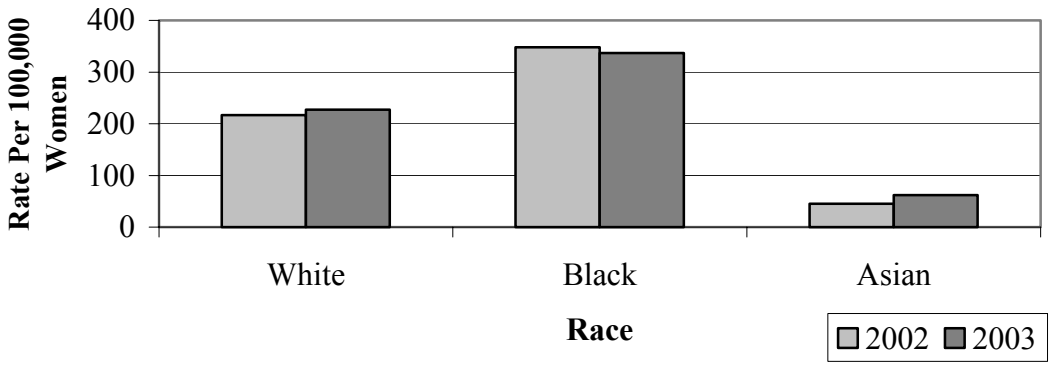
Figure 12: Natural Death Rates Among Philadelphia Women (Ages 15-60) by Age, 2002 and 2003



Source: Philadelphia Vital Statistics 2002 and 2003, Philadelphia Department of Public Health, n=2,450

Black women have the highest rates of natural death (347.9 per 100,000 in 2002 and 336.6 per 100,000 in 2003). Asian women have the lowest rates of natural death (45.2 per 100,000 in 2002 and 62.1 per 100,00 in 2003) (Figure 13).

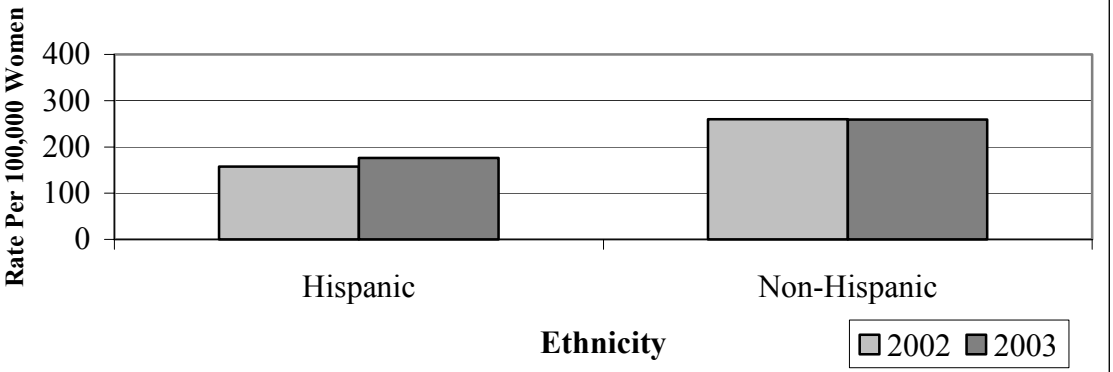
Figure 13: Natural Death Rates Among Philadelphia Women (Ages 15-60) by Race, 2002 and 2003



Source: Philadelphia Vital Statistics 2002 and 2003, Philadelphia Department of Public Health, n=2,450

Non-Hispanic women have higher natural death rates (259.6 per 100,000 women in 2002 and 258.9 per 100,000 women in 2003) than do Hispanic women (Figure 14).

Figure 14: Natural Death Rates Among Philadelphia Women (Ages 15-60) by Ethnicity, 2002 and 2003

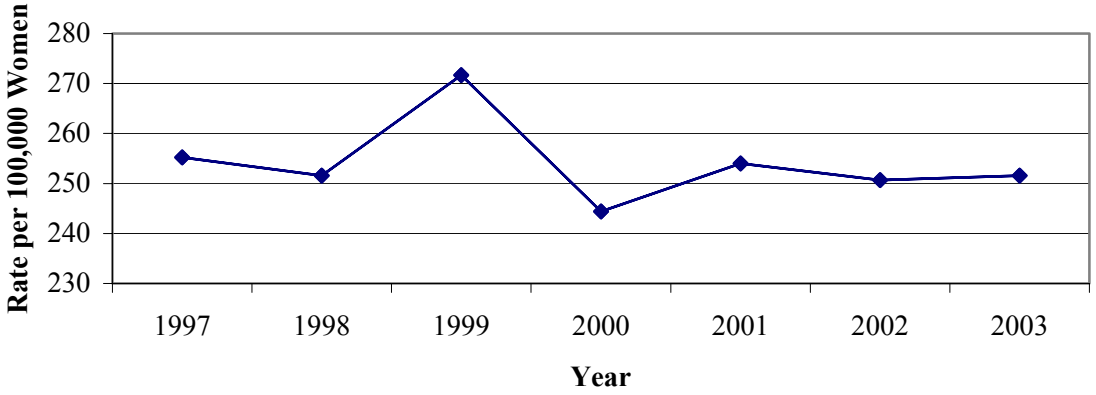


Source: Philadelphia Vital Statistics 2002 and 2003, Philadelphia Department of Public Health, n=2,450

Natural Deaths, 1997-2003

From 1997 to 2003 there were 8,476 natural deaths among women ages 15 to 60 in Philadelphia. PWDRT reviewed 1,343 of these natural deaths. Of the natural deaths reviewed, 84 (6%) had a known history of DV. The natural death rate among Philadelphia women ages 15 to 60 varies by year, with the highest natural death rate in 1999 (271.7 per 100,000 women) (Figure 15).

Figure 15: Trends in Natural Death Rate Among Philadelphia Women (Ages 15-60), 1997-2003



Source: Philadelphia Vital Statistics 1997-2003, Philadelphia Department of Public Health, n=8,476

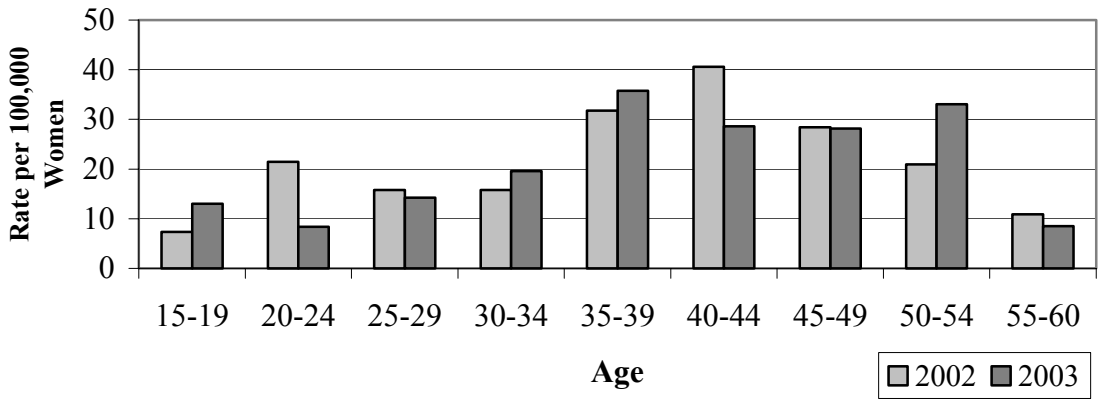
Natural deaths are the most common manner of death among Philadelphia women (Ages 15-60); central Philadelphia has the highest rates of deaths due to natural causes among this population. A summary of natural death rates by zip code is available in Appendix G, Map 3.

IV. Unintentional Injury

Unintentional Injury Deaths, 2002 and 2003

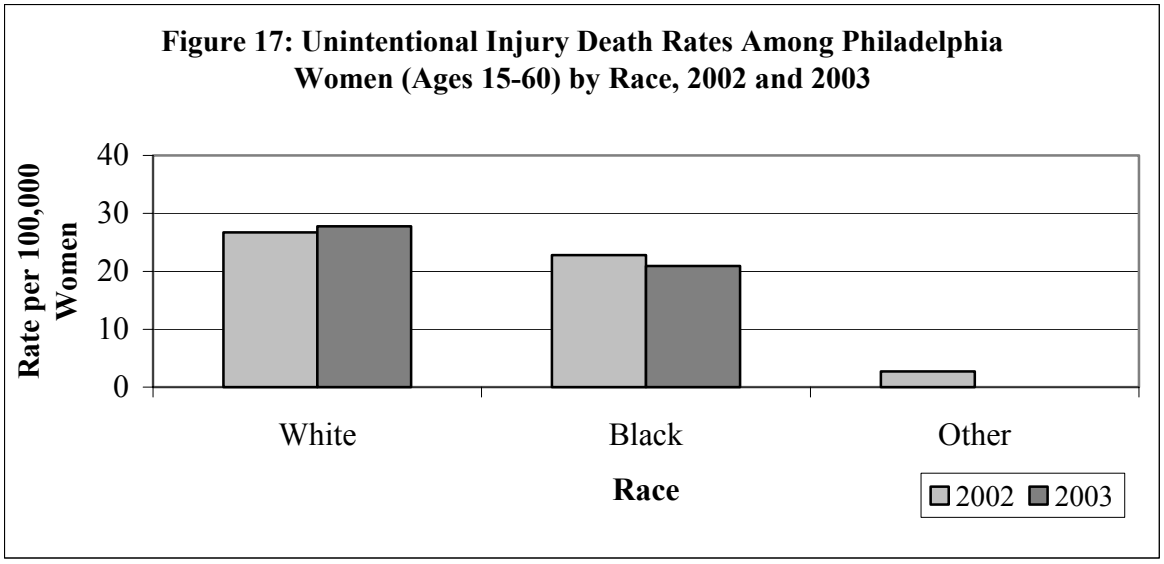
One out of four women PWDRT reviewed who died in 2002 and 2003 died as a result of unintentional injuries (n=177). Unintentional injuries include accidental deaths such as motor vehicle crashes, falls, drownings, and poisonings (including drug overdoses). Philadelphia County unintentional injury death rates for women, ages 15 to 60, in 2002 and 2003 were 21.7 and 21.0 per 100,000 women, respectively. There are higher rates of unintentional injury deaths in the middle age groups. Women ages 40 to 44 having the highest unintentional injury rate at 40.6 deaths per 100,000 women in 2002, and women ages 35 to 39 having the highest unintentional injury rate of 35.7 deaths per 100,000 women in 2003 (Figure 16).

Figure 16: Unintentional Injury Death Rates Among Philadelphia Women (Ages 15-60) by Age, 2002 and 2003



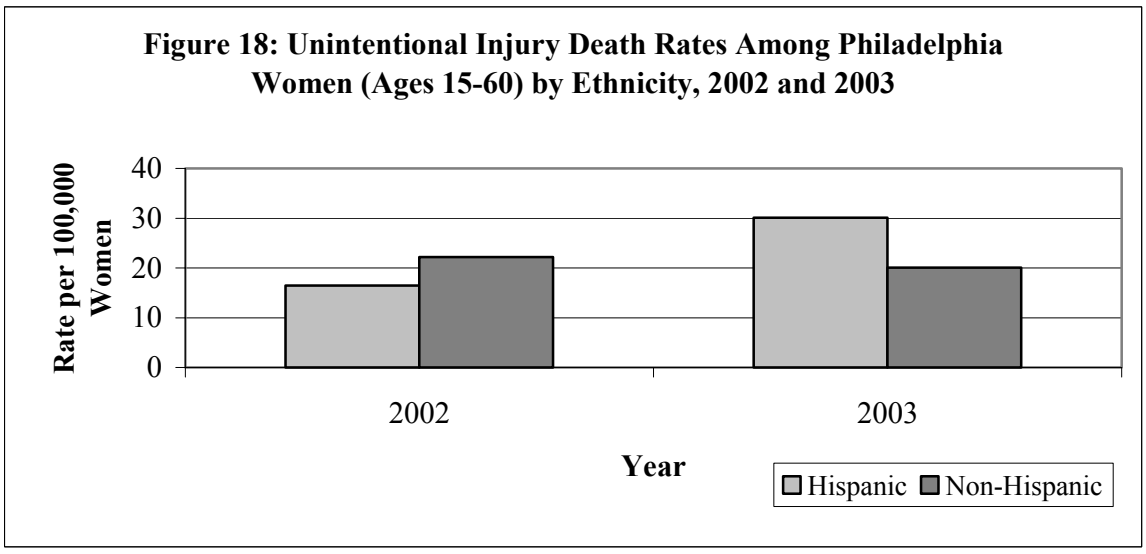
Source: Philadelphia Vital Statistics 2002 and 2003, Philadelphia Department of Public Health, n=208. PWDRT did not review all unintentional injury deaths during this time period (n=177).

In both 2002 and 2003, White women had the higher rates of unintentional injury at 26.7 deaths per 100,000 White women in 2002, compared to 22.8 in Black women; and 27.8 deaths per 100,000 White women in 2003, compared to 20.9 in Black women. There were no unintentional injury deaths among Asian women in either 2002 or 2003, and the rate for women of "other" race was relatively low at 2.7 deaths per 100,000 in 2002, and no deaths in 2003 (Figure 17).



Source: Philadelphia Vital Statistics 2002 and 2003, Philadelphia Department of Public Health, n=208. PWDRT did not review all unintentional injury deaths during this time period (n=177).

Figure 18 shows unintentional injury death rates for Philadelphia women by Hispanic origin. In 2002, the rate for Non-Hispanic women is more than that of Hispanic women (16.5 per 100,000 and 22.17 per 100,000, respectively), but in 2003, the reverse is true: the rate for Hispanic women is more than that of Non-Hispanic women (30.1 per 100,000 vs. 20.1 per 100,000, respectively).

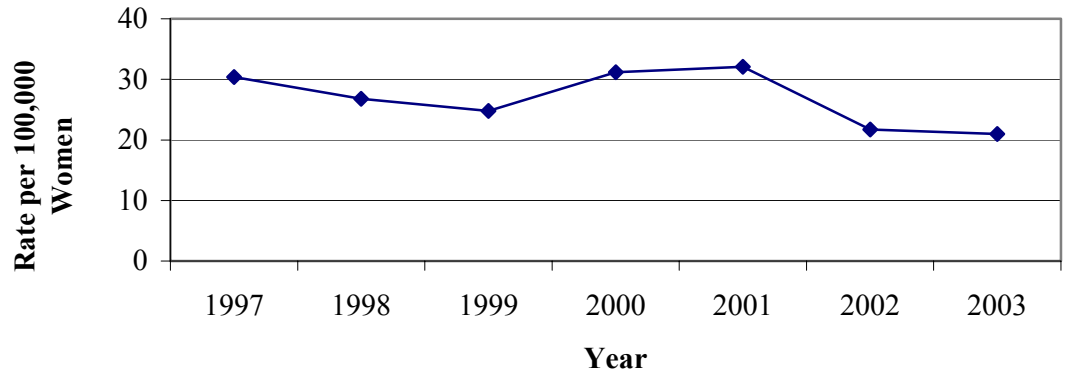


Source: Philadelphia Vital Statistics 2002 and 2003, Philadelphia Department of Public Health, n=208. PWDRT did not review all unintentional injury deaths during this time period (n=177).

Unintentional Injury Deaths, 1997-2003

PWDRT has reviewed the deaths of 703 Philadelphia women who died as a result of an unintentional injury between 1997 and 2003. The rates of unintentional injury deaths have varied moderately during this time period, with a peak in 2001 of 32.1 deaths per 100,000 women, and a low in 2003 of 20.0 deaths per 100,000 women (Figure 19). Three east-central Philadelphia zip codes experienced high unintentional injury death rates at more than 32 deaths per 100,000 women. Southern Philadelphia also experienced elevated unintentional injury death rates. For rates by zip code see Appendix G, Map 4.

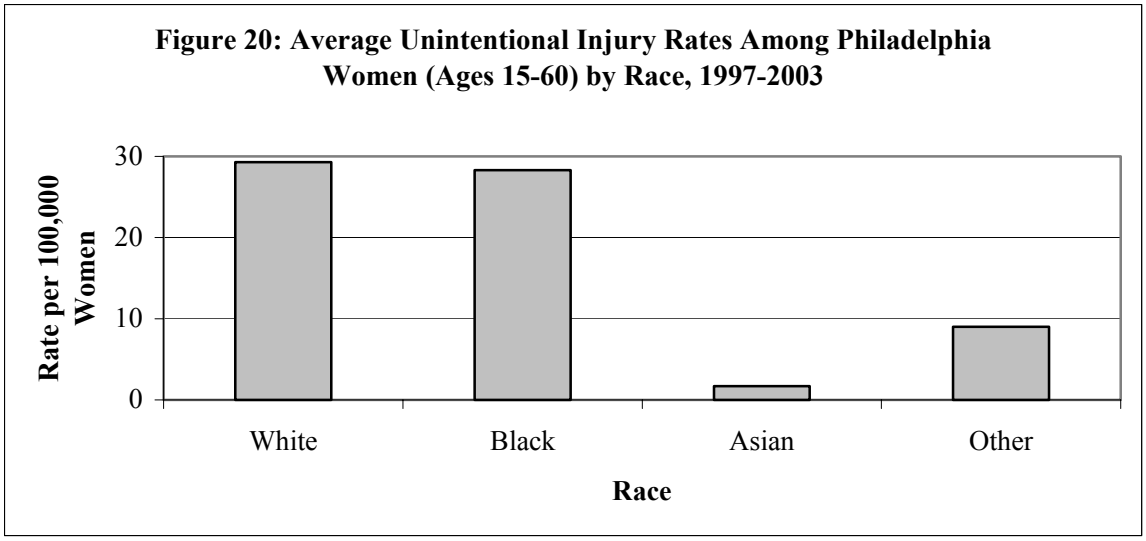
Figure 19: Trends in Unintentional Injury Rates Among Philadelphia Women (Ages 15-60), 1997-2003



Source: 2001 PWDRT Report (1997-2001) and Philadelphia Vital Statistics 2002 and 2003, Philadelphia Department of Public Health) (n=925).[12] *A total of 703 unintentional injury deaths were reviewed.*

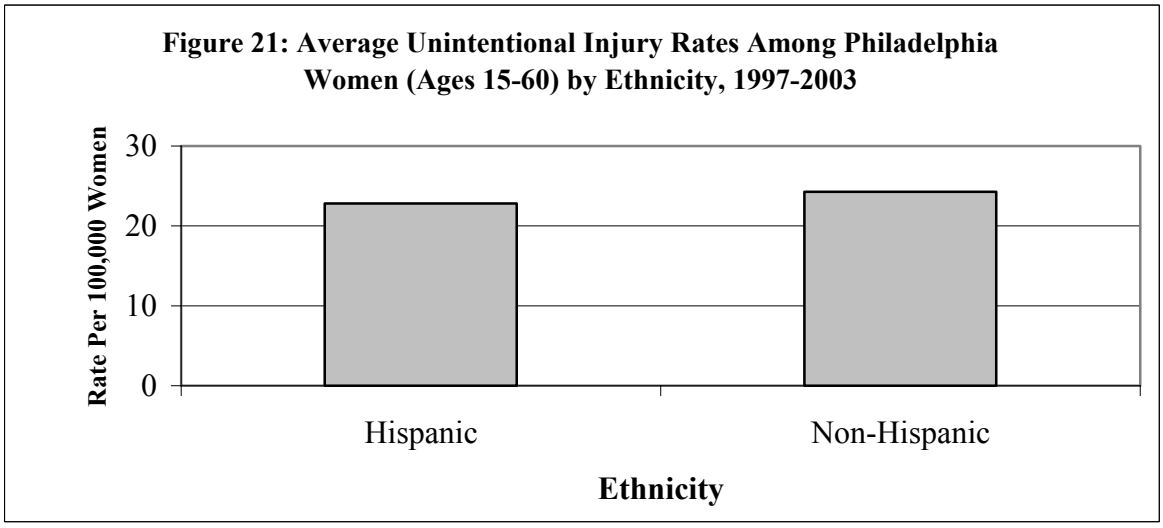
The seven-year average (1997-2003) rates of unintentional injury deaths by race are shown in Figure 20. White women had a slightly higher average rate of unintentional injury (29.3 deaths per 100,000 White women, compared to 28.3 in Black women). The rates for women of Asian and "other" races were relatively low (1.7 deaths per 100,000 Asian women and 9.0 deaths per 100,000 women of an "other" race).

[12] PWDRT was unable to use Vital Statistics data for the entire seven-year period of 1997-2003 for this analysis due to an incomplete list of E Codes, or injury codes, and thus calculated rates based on previous PWDRT reporting and available 2002 and 2003 vital statistics data.



Source: *2001 PWDRT Report (1997-2001) and Philadelphia Vital Statistics 2002 and 2003, Philadelphia Department of Public Health (n=925). A total of 703 unintentional injury deaths were reviewed.*

Figure 21 shows the seven-year average (1997-2003) of unintentional injury death rates for Philadelphia women by Hispanic origin. The rate for Non-Hispanic women is more than that of Hispanic women (24.3 per 100,000 and 22.8 per 100,000, respectively).



Source: 2001 PWDRT Report (1997-2001) and Philadelphia Vital Statistics 2002 and 2003, Philadelphia Department of Public Health. A total of 703 unintentional injury deaths were reviewed.

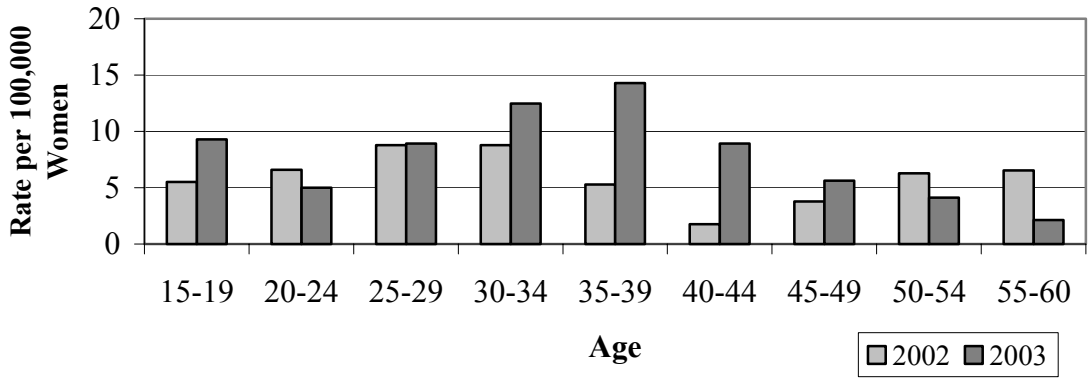
PWDRT found that between 1997 and 2003 117 women (17%) dying of an unintentional injury also had a history of domestic violence. Domestic violence is the leading cause of injury among all women (American Institute on Domestic Violence, 2001). While injuries from domestic and intimate partner violence are not always fatal it is not uncommon for women to have serious injuries prior to a fatal injury. "One study found that 44% of women murdered by their intimate partner had visited an emergency department within 2 years of the(ir) homicide" (CDC, 2005).

V. Homicides

Homicides, 2002 and 2003

PWDRT reviewed the cases of 75 homicides among Philadelphia women 15 to 60 years of age, which occurred in 2002 and 2003[13] (Figure 22); PWDRT's reviews included all homicides identified by Philadelphia Vital Statistics. These deaths accounted for ten percent of all deaths to Philadelphia women reviewed in those years. According to Philadelphia County Vital Statistics, the age-specific homicide rates for women between the ages of 15 and 60 show much variability. Because of the relatively small number of these deaths, the rates will be unstable over time.

Figure 22: Homicide Rates Among Philadelphia Women (Ages 15-60) by Age, 2002 and 2003

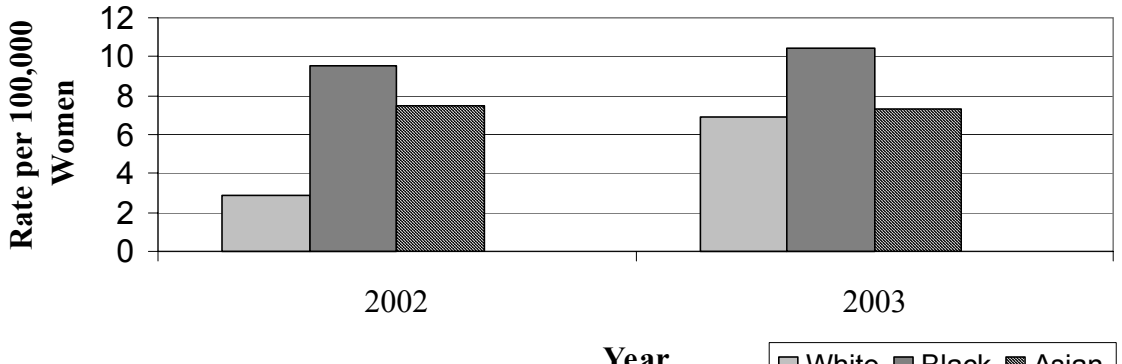


Source: Philadelphia Vital Statistics 2002 and 2003, Philadelphia Department of Public Health, n=68. PWDRT identified and reviewed an additional seven homicides during this time period.

[13] Three of the 75 homicides that occurred in 2002 and 2003 were to women who were not city residents, but had close ties to the city of Philadelphia. These cases were included in the PWDRT review, though they are not included in Philadelphia Vital Statistics figures.

Figure 23 shows homicide rates by race. In 2002, the rate for homicides among Black women is more than two times the rate for White women (9.6 homicides per 100,000 Black women and 2.9 homicides per 100,000 White women), and disparate again in 2003 (10.5 homicides per 100,000 Black women and 6.9 homicides per 100,00 White women).

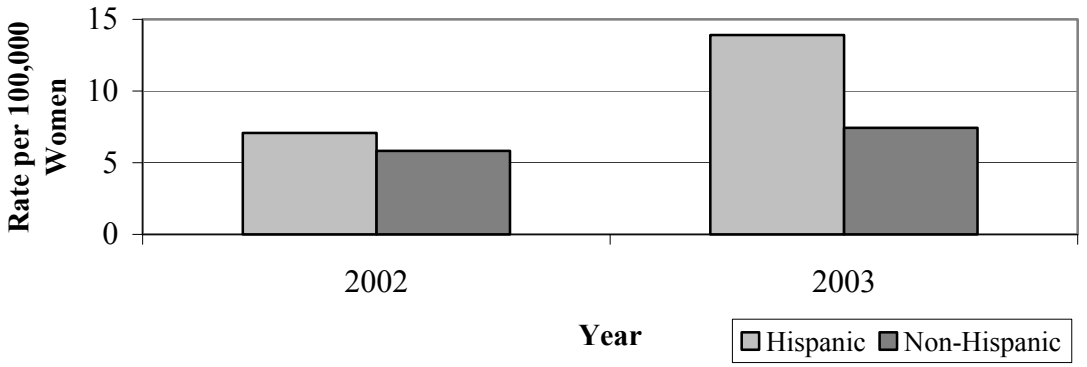
Figure 23: Homicide Rates Among Philadelphia Women (Ages 15-60) by Race, 2002 and 2003



Source: Philadelphia Vital Statistics 2002 and 2003, Philadelphia Department of Public Health, n=68. PWDRT identified and reviewed an additional seven homicides during this time period.

Figure 24 shows the homicide rate for Philadelphia women by Hispanic origin. Hispanic women have a higher homicide rate than non-Hispanic women (7.1 homicides per 100,000 Hispanic women versus 5.8 per 100,000 non-Hispanic women in 2002, and 13.9 homicides per 100,000 Hispanic women versus 7.4 among non-Hispanic women in 2003).

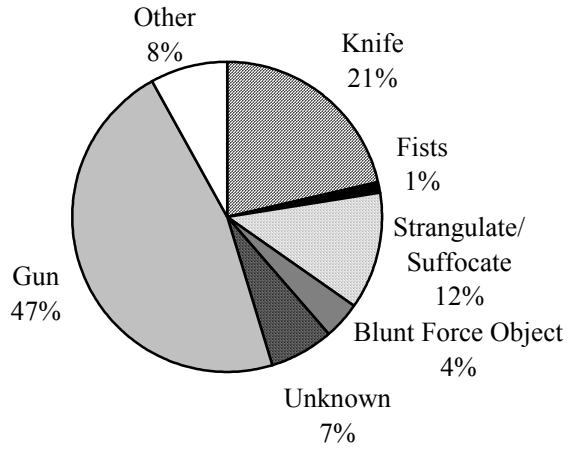
Figure 24: Homicide Rate Among Philadelphia Women (Ages 15-60) by Ethnicity, 2002-2003



Source: Philadelphia Vital Statistics 2002 and 2003, Philadelphia Department of Public Health, n=68. PWDRT identified and reviewed an additional seven homicides during this time period.

PWDRT found that guns were the predominant weapons used, accounting for 47% (n=35) of the cases (Figure 25). Out of the 35 gun cases, two involved a shotgun, 21 involved an unknown gun type, and 12 involved a handgun. Knives were used in more than one out of five cases (n=16, 21%).

Figure 25: Weapons Used in Homicide Deaths Among Philadelphia Women (Ages 15-60), 2002 and 2003



Source: PWDRT data, n=75

Of the 75 homicide victims dying in 2002 and 2003, 31 percent (n=23) had known criminal history with the justice system and five percent (n =5) of the victims were actively involved with the criminal justice system at the time of their deaths (one bench warrant and three open cases). In nine percent (n=7) of the homicide cases, the decedent had known prior involvement in prostitution.

With respect to location, 53 percent of the homicide events (n=40) occurred in the decedent's own residence. Approximately 17 percent (n=13) occurred in a street setting, and another 12 percent (n=9) occurred in someone else's residence. Two homicides took place in the victim's workplace, another in a hospital or nursing setting, one in a vehicle, and one in a recreation area. The location of the homicide was unknown or "other" in eight cases (11%).

The lives of the victims were further examined to identify women who had known history of substance abuse. It was found that in 29 percent of the homicides (n=22), the victim had a known history of substance abuse. Toxicology reports were run on 67 decedents. According to the toxicology exams, 45 percent (n=30) of the women tested positive for drugs, alcohol, or multiple substances at the time of their deaths: six for alcohol, 17 for drugs, and seven for both alcohol and drugs.

To better understand the conditions involved in the homicides, PWDRT looked at selected characteristics of perpetrators identified by the police. In 67 percent (n=50) of

the 2002 and 2003 homicide cases, the police had identified the perpetrator(s) at the time of the PWDRT review meeting. There were a total of 62 perpetrators identified. Eleven of the identified perpetrators (18%) committed suicide after the event. In 25 homicides (33%) no perpetrator was identified at the time of PWDRT review or data cleaning.

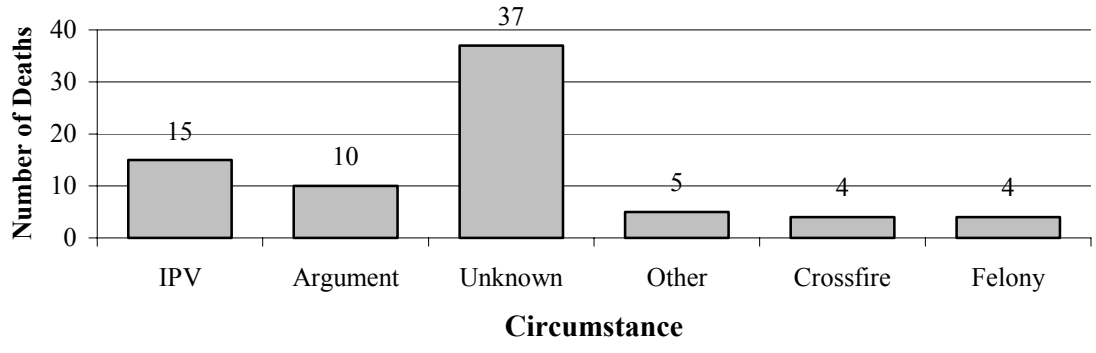
In 26 percent of the cases (n=16) where a perpetrator was identified, the perpetrator(s) had previously been arrested. Eleven percent (n=7) of the perpetrators had known active legal status at the time of the homicide: five perpetrators were on probation or parole, and two had an open case. Five other perpetrators were known to have completed any prior sentencing by the time of the homicide, and six were not known to have any prior contact with the criminal system. Definite legal status of the remaining 44 perpetrators was not determined at the time of the review meeting.

In the 2002 and 2003 homicide cases in which the perpetrator was identified, nine perpetrators were known to have substance abuse problems. Two perpetrators were known to be victims of child abuse and/or neglect.

PWDRT was also able to determine that three of the homicide victims were pregnant at the time of the death, and two were determined to have been pregnant in the year before their homicide. However, this does not represent the true number of pregnancy-associated and pregnancy-related deaths, as the data are incomplete.

With regard to circumstances surrounding the 75 homicide deaths (Figure 26), PWDRT found that intimate partner violence (IPV) was the most frequent known circumstance of all homicide cases at 40 percent (n=30). This percent reaches above 70 percent when homicide cases with unknown circumstances are not included in the analysis. Thirty-one percent (n=23) of all 2002 and 2003 homicides of women age 15 to 60 remained unsolved after one year (the approximate time of PWDRT case review). Twenty (27%) of the homicide victims had a known history of domestic violence.

Figure 26: Homicides of Philadelphia Women (Ages 15-60) by Circumstance of Death, 2002 and 2003

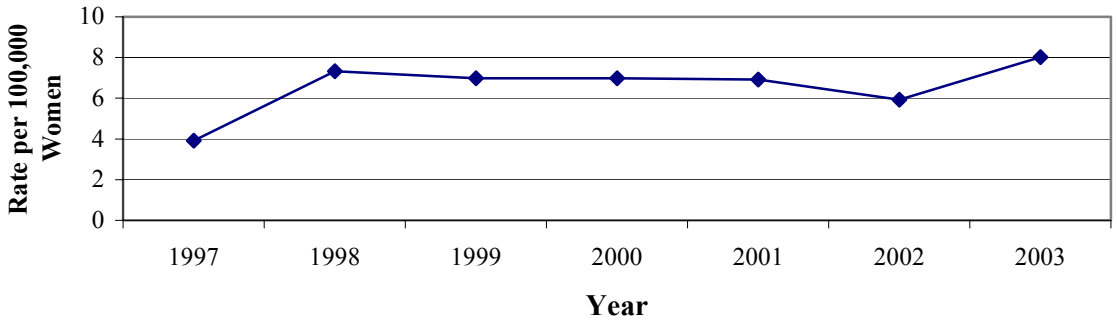


Source: PWDRT data, n=75

Homicides, 1997-2003

PWDRT reviewed the cases of 275 Philadelphia women who died as a result of homicide between 1997 and 2003. More than one in four homicide victims had a known history of DV (28%, n=78). Figure 27 shows the rates of homicide to Philadelphia women during the seven year time period. The lowest rate was in 1997 (3.9 per 100,000 women) and the highest was in 2003 (8.0 per 100,000 women), although the rate during intervening years was level.

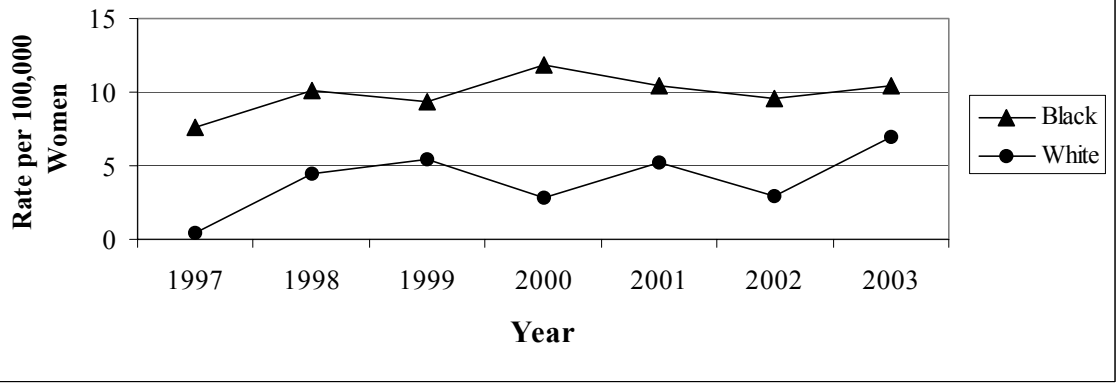
Figure 27: Trends in Homicide Rates Among Philadelphia Women (Ages 15-60), 1997-2003



Source: Philadelphia Vital Statistics 1997-2003, Philadelphia Department of Public Health, n=219. PWDRT identified and reviewed an additional 56 homicides during this time period.

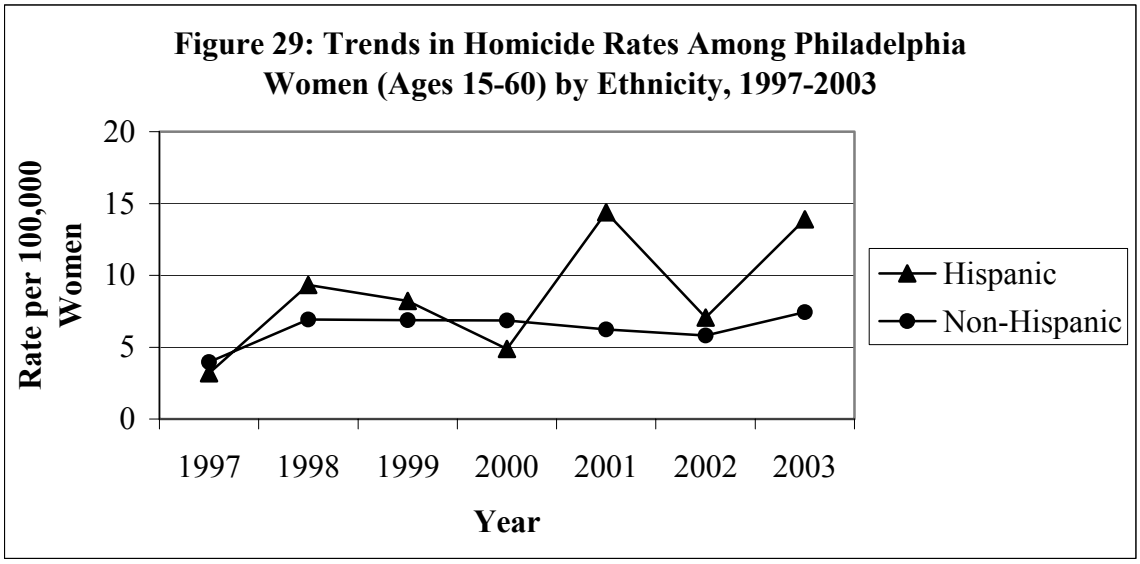
Between 1997 and 2003, the homicide rate was consistently greatest among Black women, compared to both White and Asian women (Figure 28); White women experienced the lowest homicide rate for five of the seven years studied, compared to both Black and Asian women.

Figure 28: Trends in Homicide Rates Among Philadelphia Women (Ages 15-60) by Race, 1997-2003



Source: Philadelphia Vital Statistics 1997-2003, Philadelphia Department of Public Health, n=219. PWDRT identified and reviewed an additional 56 homicides during this time period.

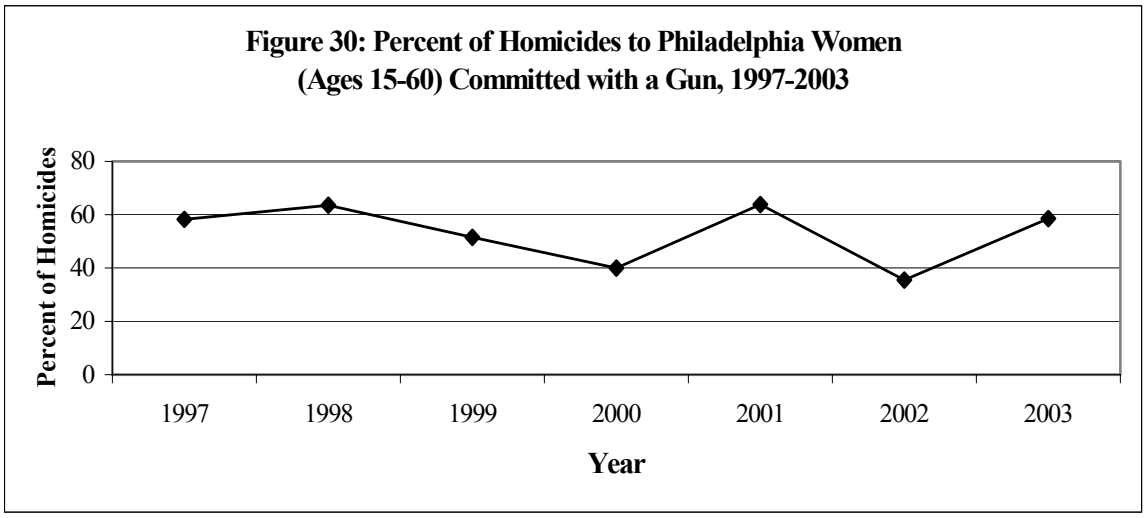
Between 1997 and 2003, Hispanic women experienced a higher homicide rate than Non-Hispanic women during in all but two year (1997 and 2000) (Figure 29)[14].



Source: Philadelphia Vital Statistics 1997-2003, Philadelphia Department of Public Health, n=219. PWDRT identified and reviewed an additional 56 homicides during this time period.

Between 1997 and 2003, 187 reviewed deaths were gun-related (including 145 homicides, 40 suicides and 2 undetermined deaths). Gun-related deaths represent 53 percent of homicides and seven percent of all violence-associated deaths reviewed by PWDRT. Certain zip codes experienced clusters of gun-related homicides, while approximately one-quarter of Philadelphia zip codes experienced no gun-related homicides during the seven-year period (Appendix G, Map 7). Figure 30 shows the percent of homicides committed with a gun (of any type) between 1997 and 2003. Twenty-four percent (n=65) of 1997 to 2003 homicides remained unsolved after one year (the approximate time of PWDRT case review). Locations of unsolved homicides are dispersed throughout Philadelphia; most are located within the central region of the county (Appendix G, Map 8).

[14] The variability of Hispanic homicide rates among Philadelphia women is emphasized by the small Hispanic population of Philadelphia women in this age group, such that each death greatly impacts the homicide rate. For instance, homicide rates among this population were lowest in 1997 at 3.19 per 100,000 Hispanic women, and highest in 2003 at 14.38 deaths per 100,000 Hispanic women. However, these rates represented a difference of five deaths, the death of one woman in 1997 and six in 2003.



Source: PWDRT data, n=145

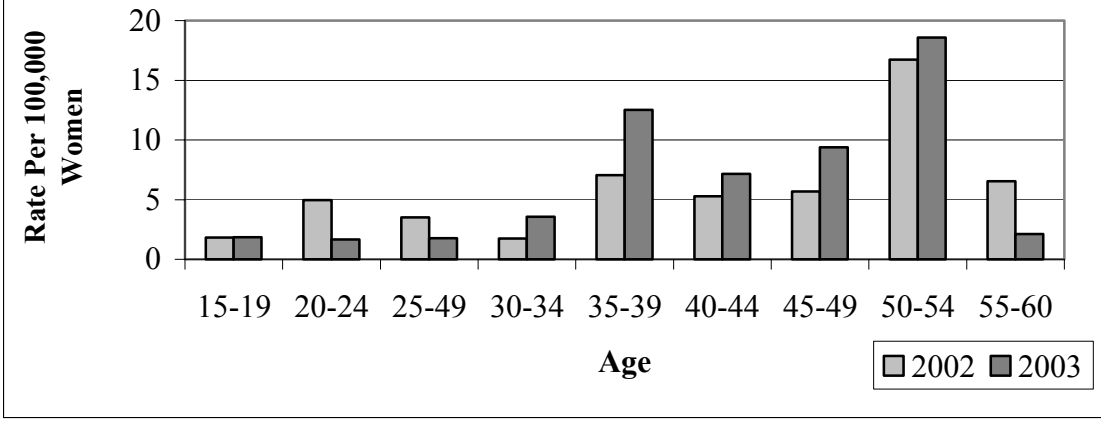
VI. Suicides

Suicides, 2002 and 2003

Suicide deaths accounted for two percent of all deaths among Philadelphia women ages 15-60 in 2002 (n=28) and in 2003 (n=31). In 2002, the suicide death rate for Philadelphia women ages 15 to 60 was 5.7 per 100,000 and this rate increased to 6.4 per 100,000 women in 2003.

The highest suicide rates by age were for women ages 50 to 54 (16.7 per 100,000 in 2002 and 18.6 per 100,000 in 2003), followed by women ages 35 to 39 (7.1 per 100,000 in 2002 and 12.6 per 100,000 in 2003) (Figure 31).

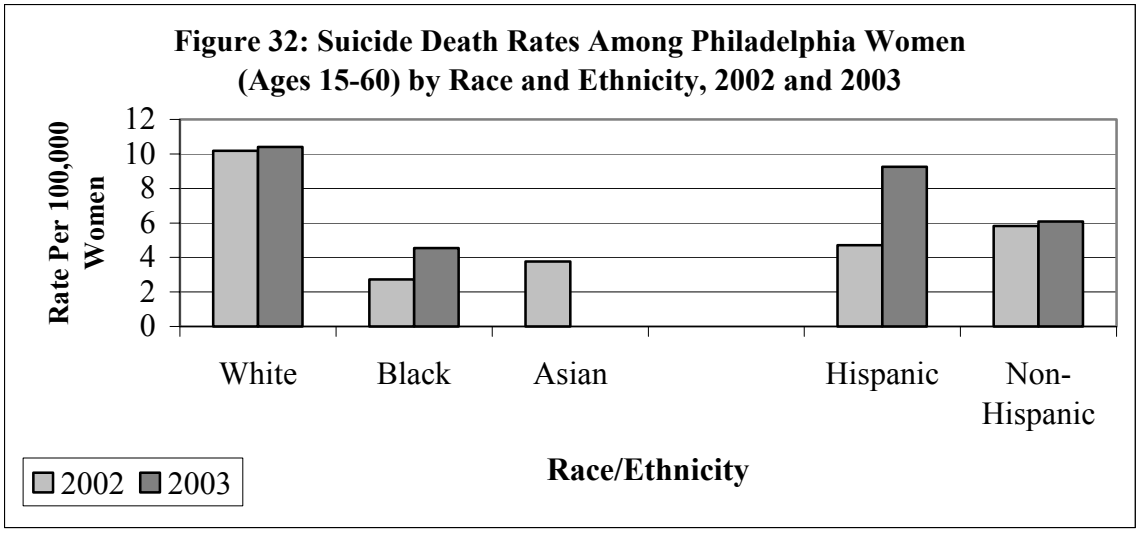
Figure 31: Suicide Death Rates Among Philadelphia Women (Ages 15-60) by Age, 2002 and 2003



Source: Philadelphia Vital Statistics 2002 and 2003, Philadelphia Department of Public Health, n=59. PWDRT identified and reviewed two fewer suicides during this time period (n=57).

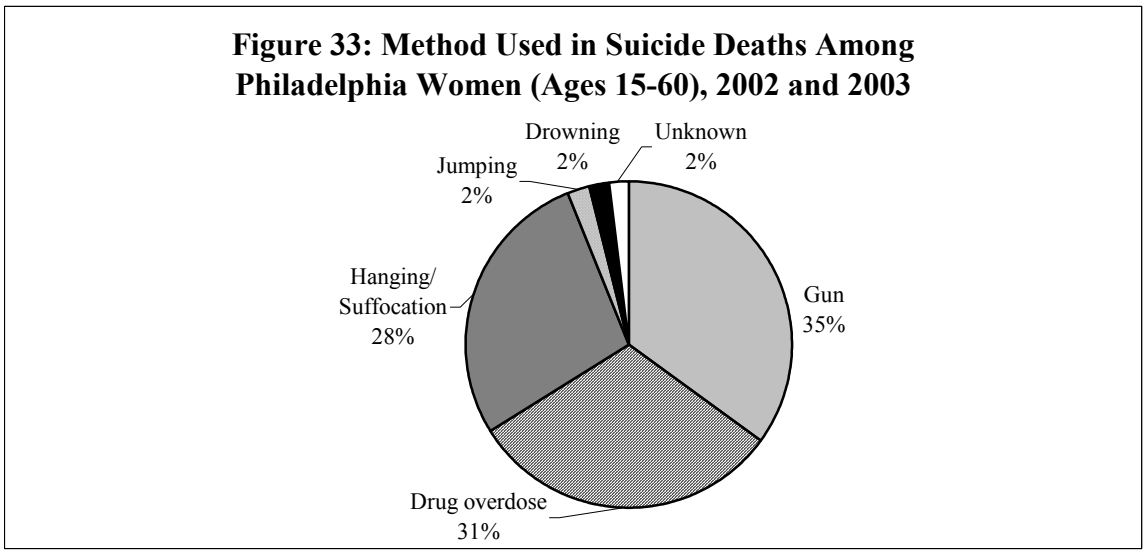
White women ages 15 to 60 in Philadelphia had the highest suicide death rates in 2002 and 2003 when compared to women of other races (10.2 per 100,000 women and 10.4 per 100,000 women, respectively). In 2003 there were no suicide deaths among Asian women in Philadelphia (Figure 32).

The suicide rate among Hispanic women in Philadelphia increased two-fold from 4.7 per 100,000 women in 2002 to 9.3 per 100,000 women in 2003; however this change may be evident only because of the small number of women in this group, showing more fluctuation between years. The suicide rate among Non-Hispanic women increased only slightly (Figure 32).



Source: Philadelphia Vital Statistics 2002 and 2003, Philadelphia Department of Public Health, n=59. PWDRT identified and reviewed two fewer suicides during this time period (n=57).

PWDRT identified and reviewed 57 suicide deaths among Philadelphia women ages 15-60 in 2002 and 2003. The Team found that 84 percent of suicides occurred in the decedent's home (n=48). Among the cases reviewed by PWDRT, the top three methods/weapons used in suicides were guns (n=20), drug overdoses (n=18) and hangings/suffocations (n=16) (Figure 33).



Source: PWDRT data, n=57

Toxicology investigations were conducted in 48 suicide cases, of which 77 percent had positive findings for either alcohol (n=2), drugs (n=26) or both alcohol and drugs (n=9). Upon review, 11 of these decedents (23%) were known to have a history of substance abuse.

Thirty-one decedents were known by Community Behavioral Health (CBH) or other agencies to have a mental health history (N=31). In 11 cases the decedents were known by CBH to have a history of depression, four were known to be bi-polar and two were known to have an anxiety disorder. In addition, four of the decedents had previously displayed suicidal behaviors.

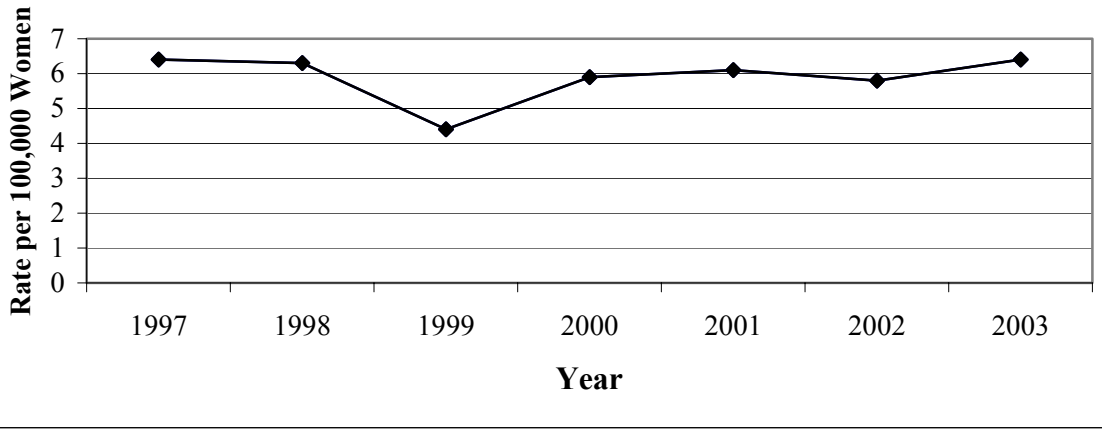
Upon review, 12 of the decedents were known to have living children. Three of the decedents were known to be victims of child sexual abuse and one had a known history of physical abuse as a child. The Team also found that one of the decedents had been homeless and had a history of prostitution, and that 10 of the victims were known by Family Court. Five women who died by suicide (9%) had a known history of DV.

Two women who committed suicide were intimate partners who chose to commit suicide together when one was terminally ill. While this situation was unique among women who died in 2002 and 2003, it suggests a need to examine services and resources (i.e., health insurance, support groups, and hospital visitation rights) that are available to same-sex and/or un-married partners facing illness.

Suicides, 1997-2003

From 1997 to 2003, PWDRT identified and reviewed 196 suicide deaths among Philadelphia women ages 15-60. Suicide deaths accounted for two percent of all deaths among Philadelphia women ages 15 to 60 from 1997 to 2003 (n=196). The suicide death rate for Philadelphia women ages 15-60 has remained relatively steady over time, with the highest suicide rate of 6.4 per 100,000 in 1997 and a slight decline in 1999 (4.4 per 100,000 women) (Figure 34).

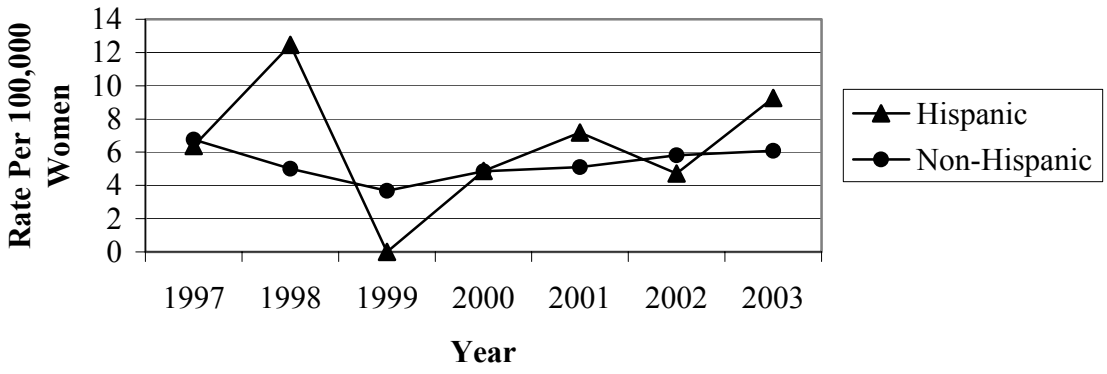
Figure 34: Trends in Suicide Rates Among Philadelphia Women (Ages 15-60), 1997-2003



Source: Philadelphia Vital Statistics 1997-2003, Philadelphia Department of Public Health, n=182. PWDRT identified and reviewed an additional 14 suicides during this time period.

While the overall suicide death rate of Philadelphia women appears to remain constant, there is a fluctuation in Hispanic suicide death rates (Figure 35). However, the fluctuation appears extreme because of the small population size of the Hispanic community of women in this age group. For instance, the suicide rate of Hispanic women peaked at 12.46 deaths per 100,000 Hispanic women in 1998, and dropped to 0.0 deaths per 100,000 Hispanic women in 1999, but these rates represent 4 suicide deaths in 1998 and zero in 1999. In contrast, Non-Hispanic suicide death rates peaked in 1997 at 6.76 deaths per 100,000 Non-Hispanic women, with a low of 3.67 deaths per 100,000 Non-Hispanic women in 1999; these rates represent 29 and 16 women respectively.

Figure 35: Trends in Suicide Rates Among Philadelphia Women (Ages 15-60) by Ethnicity, 1997-2003



Source: Philadelphia Vital Statistics 1997-2003, Philadelphia Department of Public Health, n=182. PWDRT identified and reviewed an additional 14 suicides during this time period.

Between 1997 and 2003, 13 women (7%) who died by suicide had a known history of DV. Some zip codes experienced no suicides during this time period, but seven zip codes experienced high suicide death rates at more than eight deaths per 100,000 women. For rates of suicide by zip code see Appendix G, Map 9.

VII. Undetermined Manners of Death

Undetermined Deaths, 2002 and 2003

In 2002 and 2003, 34 deaths were classified as undetermined; that is, the Medical Examiner, while identifying the cause of death, was unable to determine the manner of death at the time the death certificate was completed. On some occasions, these may be reclassified as homicide, suicide, or unintentional injury after further investigation.

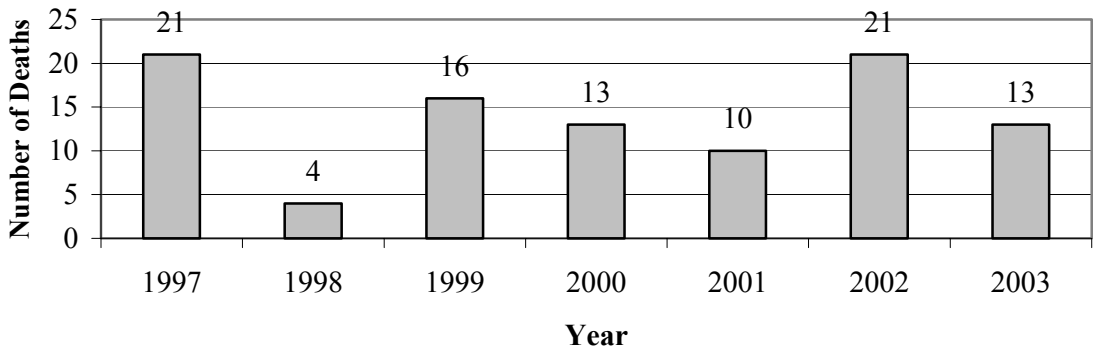
PWDRT reviewed all 34 deaths to Philadelphia women ages 15 to 60, who died in 2002 and 2003, in which the manner of death was undetermined; these deaths accounted for five percent of all deaths reviewed. Seventeen of the women were White and 15 were Black, and two were Asian; all but two women were non-Hispanic.

The most common causes of death listed for these women included long term effects of drug/alcohol abuse and adverse effects of drug(s) (44%, n=15). Eleven of the cases had questionable circumstances[15], and in one case the decedent was pregnant. Six women with an undetermined manner of death had a known history of domestic violence (18%).

Undetermined Deaths, 1997-2003

Between 1997 and 2003, 98 deaths to Philadelphia women were classified as undetermined. Figure 36 shows the number of undetermined deaths per year during this timeframe, and Figure 37 shows the rate of undetermined deaths per year during this time.

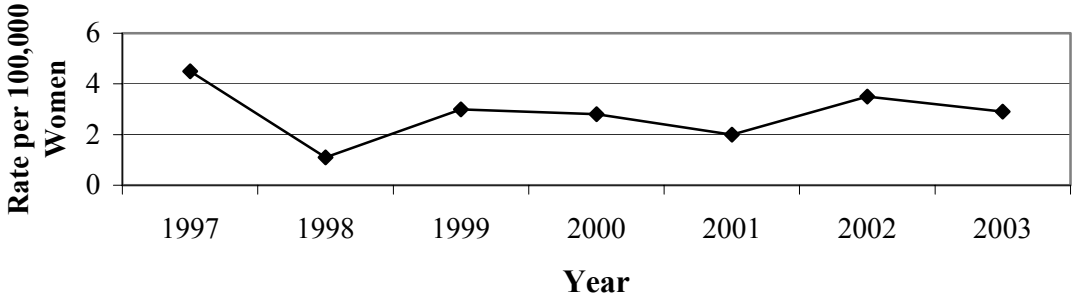
Figure 36: Number of Undetermined Deaths Among Philadelphia Women (Ages 15-60), 1997-2003



Source: PWDRT data, n=98

[15] The Clinical Screening Committee determines which cases are considered "questionable," such as cases for in which the manner of death listed on the death certificate is suspected to be incorrect, or cases with particularly uncommon situations. For further discussion, please refer to the Questionable Circumstance section of the report.

Figure 37: Trends in Rate of Undetermined Deaths Among Philadelphia Women (Ages 15-60), 1997-2003



Source: Philadelphia Vital Statistics 1997-2003, Philadelphia Department of Public Health, n=95. PWDRT identified and reviewed three additional undetermined deaths during this time period.

The two most common causes of death listed for these women were drug related, either long term effects of drug/alcohol abuse or adverse effects of drug(s) (39%, n=38). Thirty-eight (39%) of the undetermined cases had questionable circumstances, and in three cases, the decedent was pregnant. Fourteen of the women (14%) dying with an undetermined manner of death between 1997 and 2003 had a known history of DV. While the differences between average annualized rates of undetermined deaths by zip code is small, four zip codes experienced undetermined death rates of more than 6 deaths per 100,000 women. For rates by zip code see Appendix G, Map 10.

Chapter 5. Circumstances of Death: Gun-Related, Drugs and Alcohol, HIV/AIDS and Questionable Deaths

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I. Gun-Related Deaths

Gun-Related Deaths, 2002 and 2003

Between 2002 and 2003, 55 deaths reviewed by PWDRT were gun-related (including 35 homicides and 20 suicides). Gun-related deaths represent 8 percent of violence-associated deaths reviewed by PWDRT in 2002 and 2003.

PWDRT found that guns were the predominate weapons used in homicides, accounting for 47% (n=35) of the cases, including intimate partner homicides. Half of the cases of intimate partner homicide in 2002 and 2003 were committed using a gun (47%, n=14). Out of the 35 gun cases, two involved a shotgun, 21 involved an unknown gun type, and 12 involved a handgun.

Gun-Related Deaths, 1997- 2003

Between 1997 and 2003, 187 deaths reviewed by PWDRT were gun-related (including 145 homicides, 40 suicides and 2 undetermined deaths). Gun-related deaths represent 7 percent of violence-associated deaths reviewed by PWDRT since 1997.

Gun-related deaths represent 53 percent of homicides and seven percent of all violence-associated deaths reviewed by PWDRT between 1997 and 2003. Neighborhoods that experienced the highest number of gun-related deaths to women between 1997 and 2003 include (Appendix G, Map 7):

- With 10 deaths to women each:
  - Kensington/Fairhill (19133)
  - Kingsessing/Cedar Park/Cobbs Creek (19143)
  - Germantown (19144)
- With 9 deaths to women:
  - Strawberry Mansion (19132)

II. Drug and/or Alcohol Related Deaths

Research on intimate partner violence and substance abuse shows a significant association between battering incidents and both alcohol and drug abuse (Fals-Stewart et al, 2003). Because of the strong association between violence and drug/alcohol use, PWDRT reviewed all deaths of women related to drug and/or alcohol use, including acute and long-term effects. The purpose of this analysis is to identify any history of violence in the lives of these women, as well as any involvement these women may have had with a drug/alcohol treatment program(s) prior to their deaths.

Drug and/or Alcohol Related Deaths, 2002 and 2003

Of the 711 deaths reviewed by PWDRT, 112 (16%) deaths were at least partially the result of long-term drug and/or alcohol abuse, and 179 (25%) cases were the result of adverse effects of drugs and/or alcohol; ten deaths (1%) were a result of both adverse effect of drugs and long-term drug use. Meaning that 40 percent (n=281) of the violence associated deaths among Philadelphia women between 2002 and 2003 were related to drugs and/or alcohol. Illicit substances were the most common toxicology finding among these decedents (35%, n=97), followed by anti-depressants (19%, n=54) and controlled substances (16%, n=46). The majority of these women (64%, n=181) had a known substance abuse history.

The 281 women who died as a direct result of drug and/or alcohol abuse faced a multitude of problems, most notably mental health conditions, 87 of these decedents (31%) had a known history of mental health problems. The most common mental health issues were depression (n=34), suicidal ideation (n=14), and bipolar disorder (n=13). Fifteen percent (n=42) of these women had a known history of DV.

Deaths Due to Effects of Long–Term Substance Abuse, 2002 and 2003

In 2002 and 2003, 96 women died natural deaths that were caused by the effects of long-term drug and/or alcohol abuse, such as cirrhosis of the liver. The average age of these women was 49 years. Of the 96 cases reviewed, two had a known history of sexual abuse as a child, 15 (16%) had a known history of DV, six were known to have a history of homelessness, and 52 (54%) were known to have had a history of and/or treatment for substance abuse. Additionally, 18 (19%) had a known history of mental health problems.

Deaths Due to Adverse Effects of Drugs, 2002 and 2003

This subgroup of unintentional injury deaths consists of women who died from poisoning by either ingesting a deadly substance or a deadly amount of a substance. This subgroup does not include suicide by poisoning. The Medical Examiner's Office decides whether a poisoning death is an unintentional injury (i.e., adverse effects of drugs) or a suicide. The decision is based on the levels of drugs found in the toxicology report and whether the decedent left a suicide note. Generally, those decedents who have extremely high levels of drugs in their systems at the time of death or have left a suicide note are classified as suicides. Otherwise, the decedent's death is classified as an adverse effect of drugs, and the manner is listed as accidental.

In 2002 and 2003, PWDRT identified 179 women between the ages of 15 and 60 who died from the adverse effects of drugs. The mean age for these women was 41 years. Of the 179 women who died in this manner, 54 percent (n=97) were White, 45 percent (n=80) were Black, and one percent (n=2) was of Other/Unknown race.

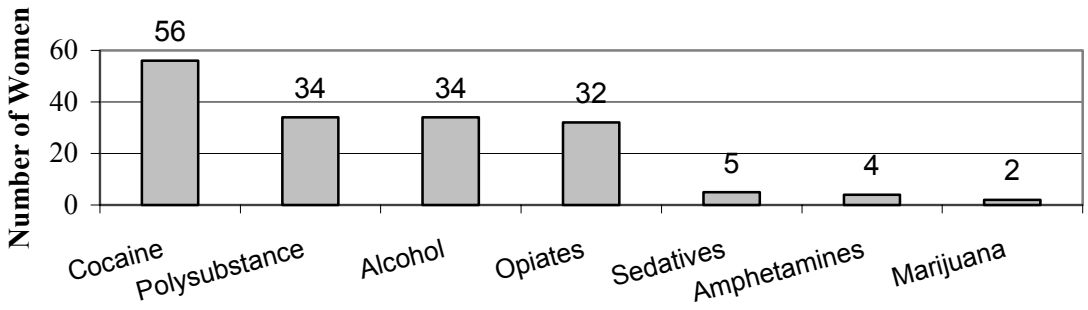
In the majority of the cases (68%, n=122), the women had a known substance abuse problem, 41 percent (n=74) of the women had a known history with criminal justice system prior to their deaths, and 16 percent (n=28) having a known history of prostitution. Additionally, 37 percent (n=66) of these women had a known history of mental health problems. Forty-one (23%) of these women had a known history of DV. Nine percent (n=16) had a known history of physical or sexual child abuse. Twenty-two of these decedents (12%) had a history of homelessness.

History of System Involvement

Of the 281 women who died due to adverse effects or long-term use of drugs and/or alcohol, 29 percent (n=81) were known to have been treated for substance abuse through Community Behavioral Health (CBH). Of those who had a substance abuse history, 75 were approved for treatment services, and 69 of these women utilized the services offered. Of those who utilized treatment services, at least six received detoxification services and five received rehabilitation services.

Of the 81 women diagnosed by CBH for substance abuse, the most common reported addictions included those for cocaine (n=56), alcohol (n=34), opiates (n=32), and polysubstance dependence (n=34) (Figure 38).

Figure 38: Substance Abuse Diagnoses Among Philadelphia Women (Ages 15-60) Known to Community Behavioral Health Who Died as a Result of Drug Use, 2002 and 2003



Source: PWDRT data, n=81

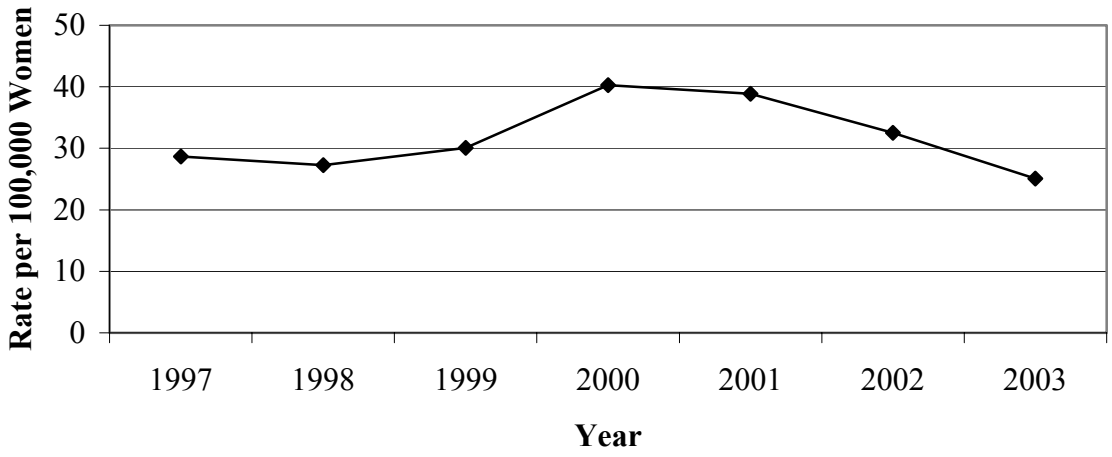
The Department of Human Services had known 84 of the decedents (30%) prior to their deaths: seven as children, 67 as parents, one as both a child and a parent, and nine as another entity. Ten of these decedents had active cases at the time of their deaths.

Forty-six decedents (16%) were involved with Family Court prior to their deaths and three (1%) had obtained a final Protection from Abuse Order (PFA). Furthermore, in one out of three cases (31%, n=86) the women had prior involvement with the criminal justice system; 27 women were involved with the system at the time of their deaths, either on bench warrant, probation/parole, with an open case, or with a warrant issued for their arrest.

Drug and/or Alcohol Related Deaths, 1997-2003

One thousand sixty-eight women (41%) died as a result of drugs and/or alcohol between 1997 and 2003. The number and rates of drug and/or alcohol related deaths of women in Philadelphia have shown increases and decreases between 1997 and 2003, with a peak in 2000 (40.3 deaths per 100,000 women), and a low in 2003 (25.1 deaths per 100,000 women) (Figure 39).

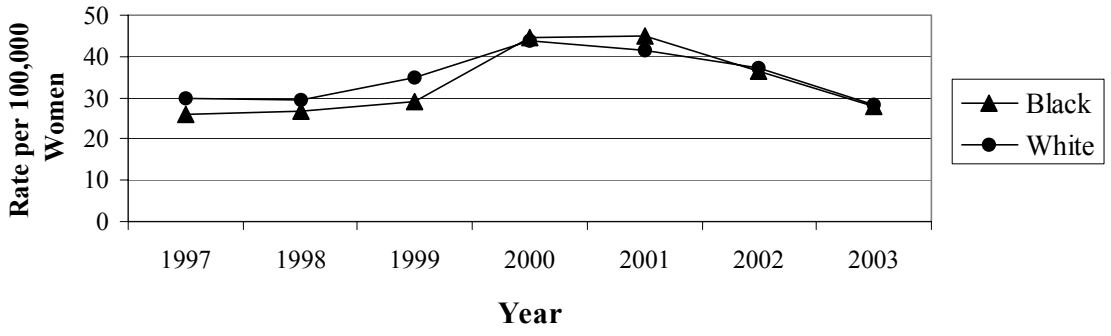
Figure 39: Trends in Rate of Drug and/or Alcohol Related Deaths Among Philadelphia Women (Ages 15-60), 1997-2003



Source: PWDRT data, n=1,068

Between 1997 and 2000, White women had a higher rate of drug and/or alcohol related deaths than did Black women, except in 2001. The rate of drug and/or alcohol related deaths steadily decreased for both Black and White women in 2002 and 2003 (Figure 40).

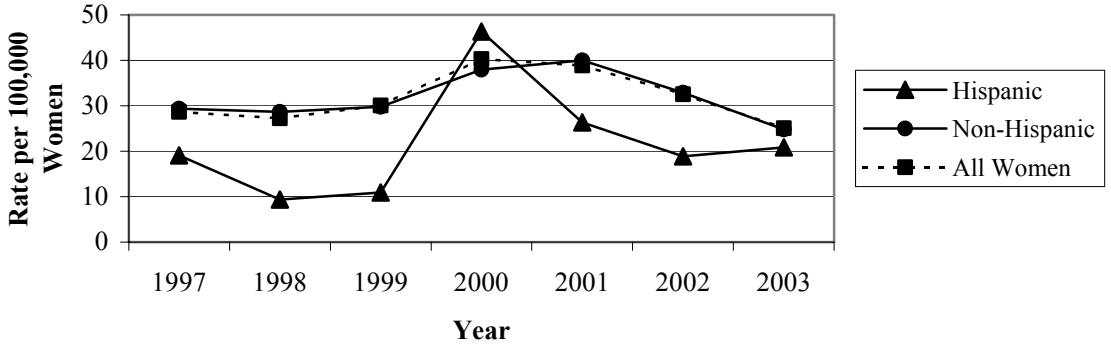
Figure 40: Trends in Rates of Drug and/or Alcohol Related Deaths Among Philadelphia Women (Ages 15-60) by Race, 1997-2003



Source: PWDRT data, n=1,068

Both Hispanic and Non-Hispanic women have experienced a decrease in drug and/or alcohol related deaths since 2001, with the decrease in rates for Hispanic women actually beginning in 2000, after peaking (Figure 41).

Figure 41: Trends in Rates of Drug and/or Alcohol Related Deaths Among Philadelphia Women (Ages 15-60) by Ethnicity, 1997-2003*



Source: PWDRT data, n=1,068

* The small number of Hispanic women in the sample causes the trend curve for Non-Hispanic women to match nearly identically with the trend for all women.

Forty-one percent (n=1,068) of the violence associated deaths among Philadelphia women between 1997 and 2003 were related to drugs and/or alcohol. Of these women, 46 percent (n=501) had a known history of substance abuse. Nine percent (n=94) had a known history of DV.

III. HIV/AIDS-Related Deaths

Just as there is a well-documented connection between violence and drug and/or alcohol abuse, so too is there a connection between HIV-positive status and violence. Women who are HIV-positive, or who have AIDS, are more likely to have led violent lives than are HIV-negative women (Wyatt et al, 2002). IPV contributes to a woman's risk and experience of HIV, as "women may become infected with HIV as a result of forced unprotected sex with an infected individual, or women may be abused as a result of disclosure of positive HIV status" (McDonnell et al, 2003, pp. 495).

HIV/AIDS-Related Deaths, 2002 and 2003

PWDRT reviewed 158 HIV/AIDS-related deaths occurring in 2002 and 2003[16]. PWDRT found that 25 (16%) of these women had a known history of involvement with prostitution, and 67 (42% of HIV/AIDS-related deaths) were known to have substance abuse problems. Based on further examination of these cases, PWDRT identified a subset of 18 women who died from HIV/AIDS-related illnesses *and* were also involved in both drug use and prostitution.[17] Fifteen percent (n=24) of decedents who were HIV-positive or who had AIDS also had a known history of DV.

Seventeen of the decedents (11%) had a known history of homelessness. People with HIV/AIDS may become financially drained by the costs of health care, may face employment problems due to discrimination or increased absences due to illness and fatigue, and are therefore at higher risk of becoming homeless (National Coalition for the Homeless, 2005a).

History of System Involvement

DHS knew 59 of the 2002 and 2003 decedents (37%) prior to their deaths: three as children, 52 as parents, three as both a child and as a parent, and one in another capacity. Five decedents had active DHS files when they died.

Fifty-eight decedents (37%) were known to the Criminal Courts for arrests prior to their deaths; four decedents had open criminal cases at the time of the decedent's death. Additionally, 27 decedents (17%) were involved with Family Court prior to their deaths.

Thirty-eight decedents (24%) had a known substance abuse history with CBH, and 31 (20%) had a known mental health history with CBH. At least one decedent who died due to HIV/AIDS had contact with or received services from each of the following agencies at some point prior to their death: Philadelphia Health Department (n=38), Emergency

[16] PWDRT identified an additional 66 women who died in 2002 and 2003 who were known to be HIV/AIDS positive. However, HIV/AIDS was not the primary cause of death or review, and these cases are therefore not included in this chapter's discussion.

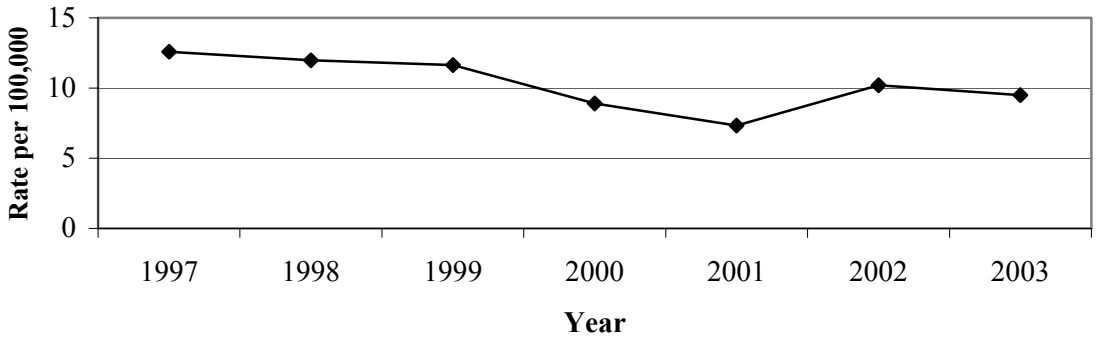
[17] While lack of condom use and/or IV drug use may have contributed to these decedents' deaths from HIV/AIDS, PWDRT has insufficient evidence to conclusively make this link.

Shelter Services (n=9), Office of Mental Health (n=6), Community legal services, Women Organized Against Rape, Women Against Abuse, and Women in Transition.[18]

HIV/AIDS-Related Deaths, 1997-2003

PWDRT reviewed 549 HIV/AIDS-related deaths (21%) among Philadelphia women that occurred between 1997 and 2003[19]. Eight percent of these women (n=42) had a known history of domestic violence. The number and rates of HIV/AIDS deaths of women in Philadelphia have slightly decreased between 1997 and 2003 (Figure 42), with rates declining from the peak in 1997 (12.6 per 100,000 women).

Figure 42: Trends in Rate of HIV/AIDS Deaths Among Philadelphia Women (Ages 15-60), 1997-2003



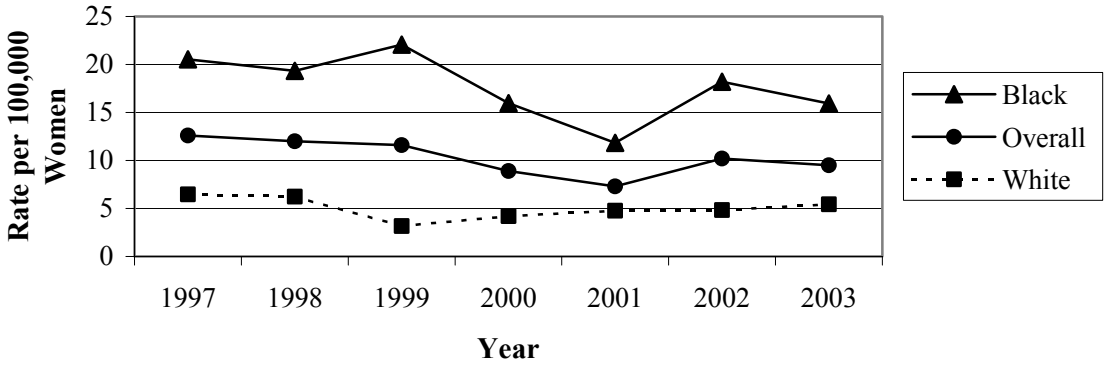
Source: Philadelphia Vital Statistics 1997-2003, Philadelphia Department of Public Health, n=343. PWDRT identified and reviewed 206 additional deaths that were in part related to HIV/AIDS.

[18] PWDRT does not have information on the extent to which decedents complied with or followed up on their contact with any of these agencies

[19] PWDRT identified and reviewed an additional 42 women who died between 1997 and 2003 who were known to be HIV/AIDS positive. However, HIV/AIDS was not the primary cause of death or review, and these cases are therefore not included in this chapter's discussion.

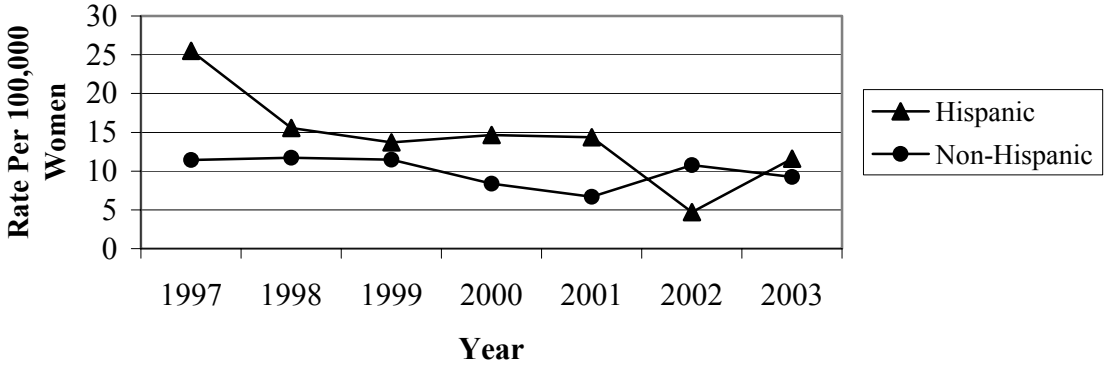
While there has been a decrease in the number and rate of HIV/AIDS-related deaths over seven years in Philadelphia, it has not been uniform across races and ethnicities. Figures 43 and 44 show the trends in the rates of HIV/AIDS deaths by race and ethnicity between 1997 and 2003.

Figure 43: Trends in HIV/AIDS Deaths of Philadelphia Women (Ages 15-60) by Race, 1997-2003



Source: Philadelphia Vital Statistics 1997-2003, Philadelphia Department of Public Health, n=343. PWDRT identified and reviewed 206 additional deaths that were in part related to HIV/AIDS.

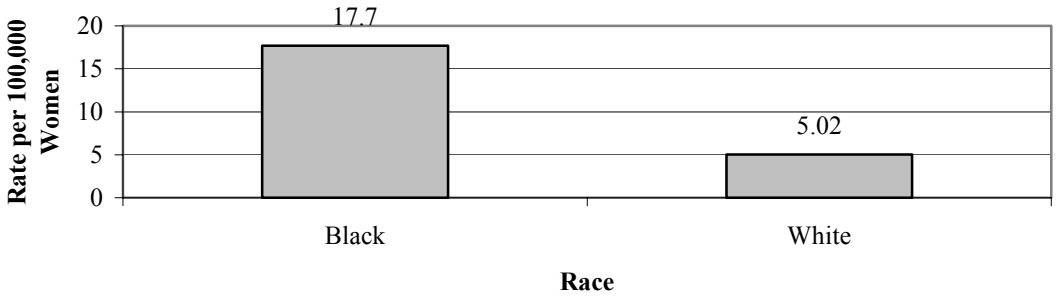
Figure 44: Trends in HIV/AIDS Death Rates to Philadelphia Women (Ages 15-60) by Ethnicity, 1997-2003



Source: Philadelphia Vital Statistics 1997-2003, Philadelphia Department of Public Health, n=343. PWDRT identified and reviewed 206 additional deaths that were in part related to HIV/AIDS.

Despite variance between years, Black women have consistently experienced a higher rate of HIV/AIDS deaths than White women. As shown in Figure 45, Black women die of HIV/AIDS at a rate more than three times that of White women.

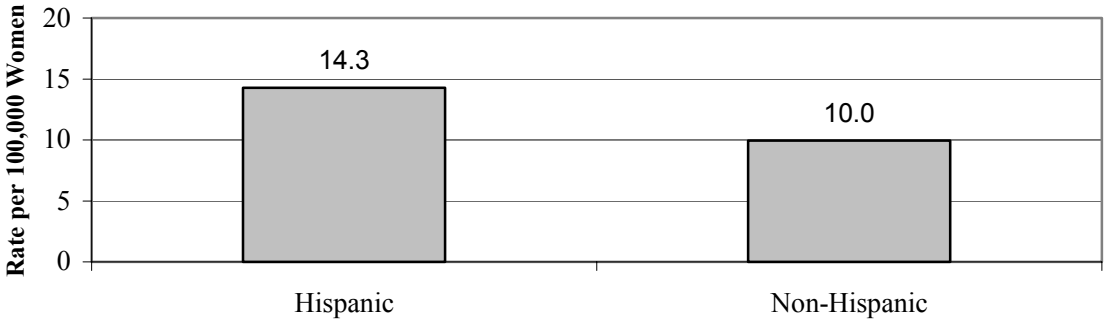
Figure 45: Average Annual HIV/AIDS Death Rate of Philadelphia Women (Ages 15-60) by Race, 1997-2003



Source: Philadelphia Vital Statistics 1997-2003, Philadelphia Department of Public Health, n=343. PWDRT identified and reviewed 206 additional deaths that were in part related to HIV/AIDS.

On average, the annual HIV/AIDS-related death rates are slightly higher for Hispanic women than Non-Hispanic women in Philadelphia, as shown in Figure 46.

Figure 46: Average Annual HIV/AIDS Death Rate of Philadelphia Women (Ages 15-60) by Ethnicity, 1997-2003



Source: Philadelphia Vital Statistics 1997-2003, Philadelphia Department of Public Health, n=343. PWDRT identified and reviewed 206 additional deaths that were in part related to HIV/AIDS.

HIV/AIDS related deaths among Philadelphia women were highly clustered in the central region of Philadelphia, while the northeast and northwest experienced comparatively few between 1997 and 2003. HIV/AIDS deaths See Appendix G, Map 11 for HIV/AIDS rates by zip code.

IV. Deaths Due to Questionable Circumstances

Deaths Due to Questionable Circumstances, 2002 and 2003

The PWDRT Clinical Screening Committee identified 59 deaths for review that they believed to have questionable circumstances in 2002 and 2003. Of these, 30 (51%) were natural deaths, 15 (25%) unintentional injuries, and 14 (24%) deaths that were of an undetermined manner. This is a heterogeneous group of deaths with uncommon situations, including cases in which there may be a suspicion of IPV, or in which there are other irregular circumstances surrounding the cause of death. "Questionable circumstances" included cases for which the Screening Committee suspected the manner of death listed on the death certificate was incorrect, such as "accidental" deaths that may have instead been suicides or the result of homicide, or cases in which it was difficult or impossible to accurately assign a manner of death due to the state of decomposition of the body at the time it was discovered.

Upon examination, the decedents reviewed in this cluster appear similar in several ways to the other women reviewed: 17 of the decedents (29%) had a known history of diagnosis and/or treatment for mental health and 17 decedents (29%) had a known history of substance abuse. Additionally, 10 of these decedents (17%) had known involvement with the criminal courts prior to their deaths. Furthermore, nine of these decedents (15%) had been involved with Family Court at prior to her death. Sixteen women (29%) had a history of domestic or intimate partner violence.

Deaths Due to Questionable Circumstances, 1997-2003

Between 1997 and 2003, PWDRT identified and reviewed a total of 373 deaths believed to have questionable circumstances. Thirty-three women (9%) had a known history of domestic or intimate partner violence.

Chapter 6. Life Circumstances: Commercial Sex Work, Homelessness, Immigrant Status, Mental Health and Pregnancy

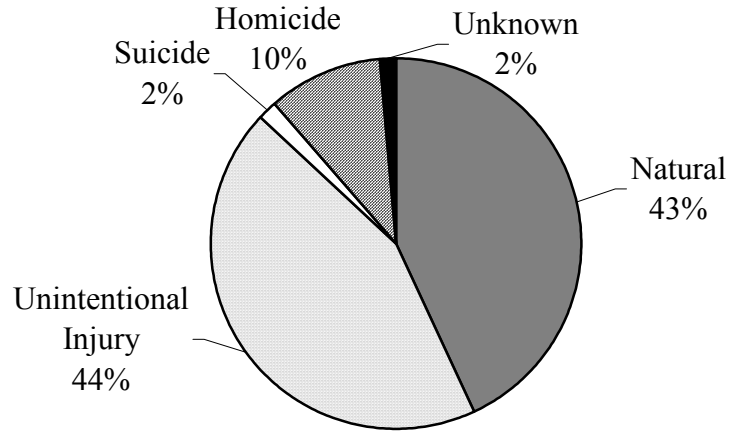
I. Commercial Sex Work

Women with a history of sex work are among the highest risk population for experiencing violence, violence-related behaviors, and ultimately premature violence-related deaths. Furthermore, sex workers who reported homelessness, substance abuse, and HIV positive status were even more likely to report lifetime experience of physical and/or sexual abuse.

Decedents with a History of Prostitution, 2002 and 2003

In 2002 and 2003, 10 percent of the decedents reviewed by PWDRT had a known history of prostitution (n=68). Among the 68 decedents known by PWDRT to have a history of prostitution, 30 died from unintentional injuries, 29 died of natural causes, 7 died of homicide, one died of suicide and one died in an unknown manner (Figure 47).

Figure 47: Manner of Death Among Philadelphia Women (Ages 15-60) with a History of Prostitution, 2002 and 2003



Source: PWDRT data, n=68. Percentages may total more than 100% due to rounding of decimal places.

The majority of the women with a known history of prostitution with unintentional injury deaths, died as a result of adverse effects of drugs (87%, n=26). Toxicology reports indicate that 27 of the 30 women who died of unintentional injury had positive toxicology results for either drugs (70%, n= 21) or drugs and alcohol (20%, n= 6) at the time of their death.

In addition to the role that drugs and alcohol played in unintentional injuries among women with a history of prostitution, women who died due to natural causes, suicide and homicide also used drugs and alcohol. In total, toxicology tests were conducted for 41 of the 68 decedents (60%) with a known history of prostitution. The results of these tests came back positive for 39 of the 41 decedents (95%).

Some of the women who died of natural causes died as a result of long-term drug and alcohol abuse, with causes of death such as cirrhosis, sepsis and liver disease. In addition, women with a known history of prostitution who died of natural causes also died as a result of HIV/AIDS (n=22). In total, 33 of the 68 decedents with a known history of prostitution were known to have HIV/AIDS (49%).

Four of the seven homicides (57%) of women with a history of prostitution were unsolved at the time of the review meeting.

The median age among decedents with a history of prostitution was 38 years of age. The majority of decedents reviewed by PWDRT with a known history of prostitution were Black (56%, n=38).

Of the decedents with a history of prostitution, the Team found that 28 had known mental health problems (41%) and 56 had a known history of substance abuse (82%). The Team also found that 6 of the decedents were known to be victims of child physical abuse or neglect (9%) and 9 were known to be victims of child sexual abuse (13%). Eighteen decedents with a history of prostitution were also known to have a history of homelessness (26%), including one woman who was currently homeless at the time of her death. In addition, 14 (21%) were known to have a history of DV.

CBH knew 71 percent of decedents with a history of prostitution prior to their deaths (N=48). The Department of Human Services knew 38 of the decedents prior to their deaths (56%). Decedents who had a history of prostitution are also known to have had contact with or received services from the following agencies: Lutheran Settlement House, Women Against Abuse shelter and legal services, Women in Transition, Women Organized Against Rape, Office of Emergency Shelter and Services, and the Office of Mental Health.

Upon review, the Team found that 90 percent of the decedents were known to the Criminal courts prior to their deaths (n=61). In addition, Family Court knew 15 decedents prior to their deaths. Six of these decedents sought Protection from Abuse orders prior to their deaths and two obtained final Protection From Abuse orders.

Decedents with a History of Prostitution, 1997-2003

From 1997 and 2003, 10 percent of the decedents reviewed by PWDRT had a known history of prostitution (n=275). As in 2002 and 2003, the majority of these decedents with a known history of prostitution died of natural causes (n=112) or unintentional injuries (n=107). The percentage of decedents with a known history of prostitution who died as a result of homicide has decreased, from 18 percent between 1997-2001 to 10 percent between 2002 and 2003. Of the women with a history of prostitution who died of homicide (16%, n=45) between 1997 and 2003, more than half (56%, n=25) represented unsolved homicides at the time of review and annual data cleaning. Thirty-one of the women (11%) with a history of prostitution between 1997 and 2003 had a known history of domestic violence in their lives. Thirty-eight percent of women with a known history of prostitution (n=105) were also known to have HIV/AIDS.

II. Homelessness

Homelessness Among Decedents, 2002 and 2003

There is a high prevalence of violence in the lives of homeless women. Domestic violence is consistently cited among the primary causes for homelessness; many women leaving an abusive relationship have nowhere to go (National Coalition for the Homeless, 2005b). Furthermore, when homeless, women are at increased risk for experiencing violence, especially while engaging in subsistence services such as the sex trade and panhandling (Wenzel et al, 2001).

PWDRT identified 61 decedents who had a history of homelessness. Eight of these women were homeless at the time of their deaths. The majority of these women were Black (67%, n=41) and non-Hispanic (97%), and their average age was 39.4 years. Seventeen (28%) women died from HIV/AIDS, 7 (11%) from the effects of long term drug/alcohol abuse, and 23 (38%) from the adverse effects of drugs. Nine of the decedents were homicide victims (15%). Four deaths had questionable circumstances. Fifty-two percent (n=32) of these decedents had a known history of mental illness, and 75 percent (n=46) had a known history of substance abuse. Furthermore, 18 of the decedents had a history of prostitution. One in four women with a history of homelessness had a known history of domestic violence (26%, n=16); five decedents had a known family history of child sexual abuse.

History of System Involvement

Over one-half of the decedents (n=33) were known to DHS as parents prior to their deaths; three as children, and 30 as parents. Seventeen decedents (28%) had prior involvement with Family Court and 34 (56%) had prior involvement with the Criminal courts. Furthermore, these decedents are known to have had contact with or received services from Community Behavioral Health (n=40), Office of Emergency Shelter Services (n=20), Health Department (n=14), Women Against Abuse, Women in Transition, Women Organized Against Rape, Office of Mental Health, and Community Legal Services.

Homelessness Among Decedents, 1997-2003

Among decedents who died between 1997 and 2003, PWDRT identified 115 decedents who had a history of homelessness, 30 of whom were homeless at the time of their death. Women with a history of homelessness primarily died natural (44%, n=51) or unintentional injury (36%, n=41) deaths; 18 women (16%) died by homicide, three (3%) by suicide, and two (2%) of undetermined causes. The majority of these women were Black (67%, n=79) and non-Hispanic (97%, n=111). Eighteen percent (n=21) of women with a history of homelessness had a known history of DV.

III. Immigrant Women

Immigrant Women, 2002 and 2003

According to the 2003 Yearbook of Immigration Statistics, 10,166 immigrants indicated Philadelphia as their intended place of residence in 2003. The size of this annual influx of immigrants necessitates an examination of violence-related deaths among the population of immigrant women. The experience of violence in the lives of immigrant women is aggravated by language and cultural barriers, economic instability, and social isolation (Raj et al, 2003). These factors influence reporting of IPV, incidence of HIV infection (Harawa et al, 2002), receipt of medical care, and knowledge of other available services.

PWDRT identified and reviewed the deaths of 32 women who were born outside the United States. Fourteen women (43%) were born in Puerto Rico, four in Germany, three in Vietnam, and one woman was born in each of the following countries: Cambodia, China, Colombia, the Dominican Republic, England, Haiti, Liberia, Nigeria, Poland, South Korea, and Trinidad.

Natural causes of death accounted for 44 percent (n=14) of deaths to immigrant women, with 43 percent (n=6) of these being AIDS deaths. Another 13 percent (n=4) of immigrant deaths were unintentional injuries due to the adverse effects of a drug(s) and questionable circumstances. Suicide accounted for 22 percent (n=7) of immigrant deaths, and homicide accounted for 16 percent (n=5) of immigrant deaths. Two of the homicide deaths were directly attributed to IPV. The manner of death for two immigrant women remains undetermined. One woman had a history of DV.

Decedent History

Six of the decedents (19%) who were immigrants had received a diagnoses and/or treatment for mental health, one of whom also had a substance abuse history; two other decedents had a substance abuse history. One of the women had a history of homelessness. None of the decedents who were immigrants had a history of prostitution.

History of System Involvement

Five of the decedents (16%) who were immigrants were known to DHS as a parent. Seven decedents had past involvement with Family Court[20], and three had at some point obtained final Protection from Abuse orders, although none received more than one final PFA. Three decedents had past involvement with the Criminal court; one decedent was on parole/probation at the time of her death, and one woman had an open case at the time of death.

Additionally, the immigrant women PWDRT reviewed were known to have had contact with or received services from the Health Department (9%, n=3) and Community Behavioral Health (28%, n=9).

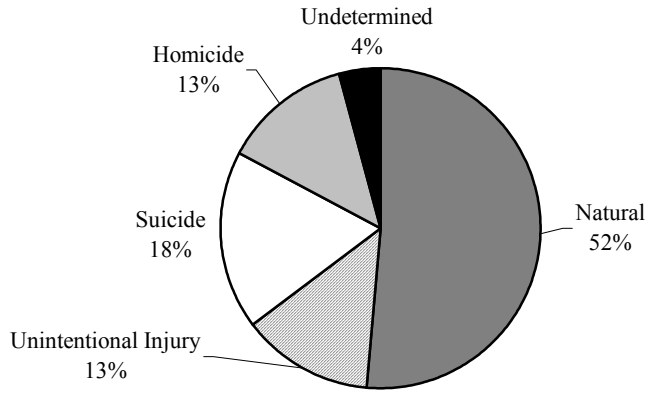
[20] Variables for contact with Family Court and number of points of contact with Family Court added for 2003 deaths, and are therefore not available for deaths that occurred before 2003.

Immigrant Women, 1997-2003

PWDRT identified and reviewed the deaths of 67 women who were born outside the United States. Thirty-three women (49%) were born in Puerto Rico, five in Germany, five in Vietnam, two in Colombia, two in Haiti, two in Poland, and one woman was born in each of the following countries: Austria, Cambodia, China, the Dominican Republic, England, India, Italy, Ivory Coast, Liberia, Morocco, Nepal, Nigeria, Poland, Romania, Scotland, South Korea, Trinidad, Virgin Islands, and West Africa.

Immigrant women died primarily of natural causes and suicide (Figure 48).

Figure 48: Manner of Death Among Immigrant Women (Ages 15-60), 1997-2003



Source: PWDRT data, n=67

Eleven immigrant women (21%) had a history of domestic violence.

IV. Mental Health History

Mental Health History Among Decedents, 2002 and 2003

Over one-quarter (28%) of the decedents reviewed by the PWDRT (n=196) had a history of, diagnosis and/or treatment for, a mental health condition. One hundred forty-four decedents (73%) with a known mental health condition were known to Community Behavioral Health's mental health programs. Of the deaths to women who had a history of diagnosis and or treatment for mental health 34 percent (n=67) were due to the adverse effects of drugs, 17 percent (n=34) were due to HIV/AIDS and 11 percent (n=22) were due to the long-term effects of drug and/or alcohol abuse. Additionally, seven percent (n=14) were homicides, 13 percent (n=26) were suicides, and nine percent (n=17) had questionable circumstances. Two decedents' deaths were pregnancy-associated, and 24 were of other circumstances. Twenty-one percent of the women reviewed in 2002 and 2003 with a known mental health treatment/diagnosis history had a known history of DV.

Eighty-seven of the decedents (44%) with a known history of mental illness were White, and 101 (52%) were Black; decedents with a known history of mental illness were also Asian, Indian, and of unknown race (n=8). Twenty-two decedents were Hispanic (11%) and 170 (87%) were non-Hispanic; the ethnic origin of four decedents (2%) was unknown.

History of System Involvement

PWDRT was able to collect information on mental health diagnoses for a portion of the 142 decedents who had a known mental health history with CBH. Fifty-two decedents were diagnosed with depression, 19 with bipolar disorder, 14 with schizophrenia, 24 with being suicidal, two with anxiety disorders, and 37 with another mental health condition. Some decedents had multiple diagnoses.

Women who had a history of a mental health illness are also known to have had contact or received services from the following agencies: Lutheran Settlement House, Women Against Abuse shelter and legal services, Women in Transition, Women Organized Against Rape, Community Legal Services, Emergency Shelter Services, Office of Mental Health, Criminal Courts, and the Health Department. Additionally, 47 women (24%) had a history with Protection From Abuse orders in Family court.

Mental Health History Among Decedents, 1997-2003

Over 500 of the decedents (19%) reviewed by the PWDRT between 1997 and 2003 had a history of diagnosis and/or treatment for a mental health condition (n=501). Two-thirds of the decedents with a known mental health history (67%, n=333) were known to either CBH or OMH. Mental health conditions can be both the cause and outcome of exposure to violence, and mental health providers can be critical players in breaking the cycle of violence. Eighteen percent of these women (n=92) had a known history of domestic violence at the time of there death.

V. Pregnancy Associated Death

Physical and sexual violence can have great negative impact on women's sexual and reproductive health. For instance, women experiencing physical and sexual violence are at increased risk for unintended pregnancies, sexually transmitted diseases, or partaking in high-risk behaviors while pregnant (i.e., smoking, or drug and alcohol abuse). The state of pregnancy itself may lead to more violence, although in some cultures, it is likely that pregnancy is a protective state for women (Ellsberg, 2005).

Recent studies have found that intimate partner homicide is a leading cause of pregnancy-associated maternal death (Horon and Cheng, 2001). It has also been noted that women who are victims of physical violence experience a greater likelihood of delayed entry into prenatal care than women who do not experience physical violence (Dietz et al, 1997).

Based on this growing body of literature evidencing that IPV is associated with deaths during or immediately after pregnancy, PWDRT examined deaths of women that occurred between 1997 and 2003 who were either pregnant at the time of their death or died within a year of giving birth.

PWDRT identified and reviewed the pregnancy-related deaths of 90 Philadelphia women who died between 1997 and 2003. Two-thirds of the women were Black (n=59, 66%), 23 were White (26%), three (3%) were Asian, and five were of other or unknown race (6%). The majority of women were non-Hispanic (89%, n=78). The average age of women who were pregnant at the time of their death or who died within a year of giving birth was 30.

There were pregnancy-associated deaths across all manners of death (Table 5).

Table 5: Number of Pregnancy Associated Deaths Among Philadelphia Women (Ages 15-60) by Manner of Death, 1997-2003

Manner of Death	N (%)
Natural	46 (51%)
Unintentional Injury	16 (18%)
Suicide	1 (1%)
Homicide	21 (23%)
Undetermined	6 (7%)

Source: PWDRT data, n=90

Overall, 11 percent of the women who were either pregnant at the time of their death or died within a year of giving birth (n=10) had a known history of domestic violence.

Fourteen of the 21 homicides to pregnant or recently pregnant women (67%) occurred while the woman was pregnant; six of the homicides (29%) were perpetrated by a current or former intimate partner (spouse or paramour). The Team would like to be able to collect information as to whether pregnancy was a reason for the homicide.

PWDRT is as yet unable to collect information as to when specifically violence first occurs to women (before, during, or after pregnancy), whether it continues, and whether it is specifically tied to the state of pregnancy. It would be useful for future analyses of the association between violence and pregnancy if the Team were able to procure this information, as well as to obtain more complete health records as to the number of women who were pregnant in the year prior to their deaths.

Chapter 7. Socioeconomic Status, Social Capital, and Violence Against Women

PWDRT examined data on the socioeconomic status of census tracts in Philadelphia. The socioeconomic status variable was created using a cluster analysis of per capita income, median household income, percentage of college graduates and percentage of professionals in a given census tract (Appendix G, Map 13). Analysis shows that there is a significant relationship between socioeconomic status and the occurrence of violent deaths among women in Philadelphia.

The majority of women who died between the years 2002 and 2003 lived in the lowest socioeconomic status neighborhoods (78%, n=555), while only eight women (1%) lived in upper-middle or upper socioeconomic status neighborhoods.

PWDRT also examined the level of social capital among Philadelphia neighborhoods, as some health researchers postulate that communities experiencing higher levels of social capital also experience protective health benefits. Social Capital is a measure of community connectedness based that takes into account five elements: civic participation, sense of community belonging, trust in neighbors, belief that neighbors look out for one another, and efforts to improve the neighborhood. Socioeconomic status was found to correlate with social capital. More than one-half of women (57%, n=395) who died between 2002 and 2003 lived in sections of Philadelphia where the social capital level was low (lower low and upper low), and just 16 women (2%) lived in neighborhoods of high social capital (Appendix G, Map 14).

Chapter 8. Child Witnesses and Secondary Victims of Violence

PWDRT examined the number of children affected by intimate partner violence. Previous research indicates that children who witness violence are traumatized, and are more likely to engage in violence as an adult (Peled and Davis, 1995; McNeal and Amato, 1998). Furthermore, these children are more likely to experience developmental difficulties, school failure, and psychiatric disorders; witnessing violence can have both short and long-term consequences on a child's well-being (Nelson et al, 2004; Groves, 2002). It is estimated that over 3.3 million children witness acts of intimate partner violence each year (American Academy of Pediatrics, 2005). This suggests that many children are at risk for potentially becoming involved in violent relationships as adults because of their traumatic experiences in childhood. In addition, the Adverse Childhood Experiences Study has shown a relationship between adverse childhood experiences, like growing up in a household where the mother is treated violently or a parent is lost during childhood regardless of cause, and various challenges in adult health, including addictive behaviors such as substance abuse and destructive behaviors such as suicide (Felitti, 2002).

Due to limitations of the data, PWDRT is not yet able to provide an accurate count of the total number of children who lose a mother to violence or who witness a homicide caused by intimate partner violence. However, analysis of the 30 cases from 2002 and 2003 of intimate partner homicide suggests that at least 15 of the decedents had children, at least 30 children lost a mother due to IPV homicide, and at least six children witnessed an intimate partner homicide.

Similarly, analysis of the 711 deaths of women who died in 2002 and 2003 indicates that at least 203 women were mothers, and approximately 465 children had a mother who died a violence-related death in 2002 or 2003. At least 62 children lost a mother to homicide. Additionally, 243 children had a mother who died a natural death. At least 115 children had a mother who died due to the adverse effects of drugs, 138 had a mother who died due to HIV/AIDS, 38 lost a mother due to the long term effects of drugs/alcohol, 24 lost a mother to suicide, and 16 lost a mother due to a death which has been deemed undetermined. Eighty-six children lost a mother who had a history of commercial sex work. Eighty-seven children lost mothers who had a history of homelessness and 12 children lost mothers who were homeless at the time of their deaths.

PWDRT identified with certainty at least 21 children who either witnessed the death of a mother, or found her body in 2002 or 2003. One-half of these cases involved a homicide (n=11). Ten of the child witnesses are known to have been provided grief counseling services. These findings are based on the 711 cases reviewed by PWDRT of deaths occurring to Philadelphia women in 2002 and 2003. Between 2001 and 2003 at least 32 children directly witnessed the death of their mother or found her body.

Between 1997 and 2003, at least 691 of the women who died were mothers. Approximately 1,540 children lost a mother. At least 293 children lost a mother to homicide, 486 to unintentional injury, and 72 to suicide. In addition, 62 children lost a mother due to undetermined causes, and 623 children lost a mother to natural causes.

Chapter 9. Service System Involvement

PWDRT's knowledge of decedent involvement with social, legal, and medical service providers comes directly from PWDRT members representing these city agencies at review meetings. Some of these agencies approve and provide services only to individuals with public insurance, therefore not necessarily capturing the complete extent of services accessed by all decedents. However, analysis of system involvement known to PWDRT can suggest the types of services and agencies most accessed by this population of women who are dying prematurely, identifying best points of intervention to empower women to escape violent relationships and modify risk behaviors.

This section describes some of the services these city agencies provide, along with seven-year trend data (1997-2003) about decedent system involvement.

It is important to recognize that trends of increased use of services might be in part a function of modified reporting systems, such that over the years, service providers have become more detailed in collecting service usage information and reporting it to PWDRT at review meetings.

Community Behavioral Health (CBH)

CBH was launched in 1997 to serve Philadelphia's Medicaid recipients, offering services to individuals with behavioral health issues, including mental health conditions and substance addictions.

Of the systems and city agencies represented on the Team, the behavioral health system has had contact with the greatest number of decedents between 1997 and 2003. PWDRT began collecting information on decedent involvement with CBH in 1997, with more detailed collection beginning in 2000 around approval for, and usage of, mental health and substance abuse services. Between 1997 and 2003, 29 percent of women reviewed by PWDRT (n=768) were known to CBH, either as a service recipient or as a relative to a service recipient.

Behavioral health agencies that address mental health and/or substance abuse should be trained to identify and deal with IPV issues, understanding that both substance abuse and mental health issues (e.g., suicidal ideation or attempts, depression, anxiety, low self-esteem, etc.) are frequently accompanied by the experience of trauma. For instance, PWDRT found that one-half of women with a history of DV or IPV also had a known history of substance abuse (49%, n=129).

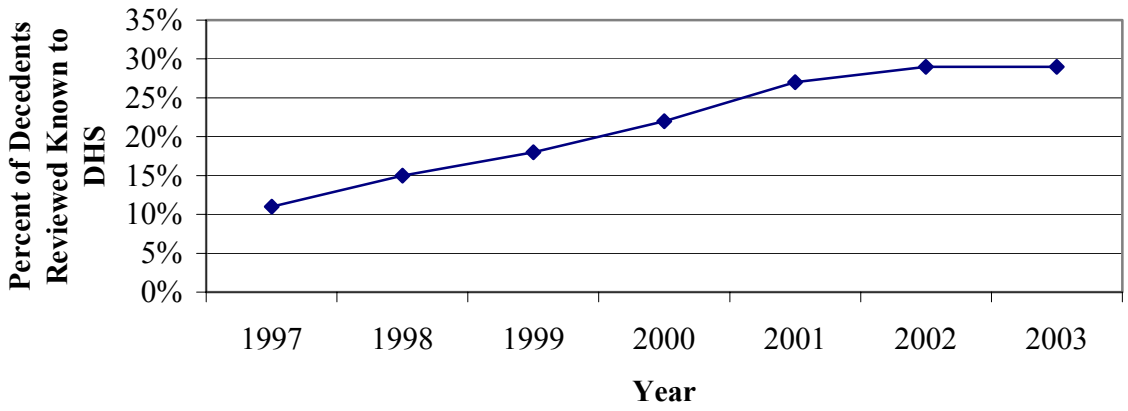
Philadelphia Department of Human Services (DHS)

DHS provides services to children and their families to protect youth from delinquency, and to ensure their safety and stability in a home environment through family preservation or dependency placement. DHS also partners with other community agencies to integrate systems to effectively serve children and their families.

PWDRT began collecting information on decedent involvement with DHS beginning in 1997. Women reviewed by PWDRT have been involved with DHS in all capacities, as children, parents, guardians, and relatives. DHS representatives share with the Team information about dependency and delinquency placements of the decedent as a youth, as well as the involvement of her siblings and children with DHS. Between 1997 and 2003, a total of 2,630 women were reviewed. Of these, 563 (21%) were known to DHS. These women were involved with DHS as a child (n=52), parent (n=470), both as a child and as a parent (n=10), or in another capacity (n=31).

Since the case selection criteria were refined in 2001 to focus further on violence related deaths, the percentage of women known to DHS has increased (Figure 49), demonstrating the opportunity for DHS to serve as a point of intervention in the lives of women at risk for violence.

Figure 49: Percent of Philadelphia Women (Ages 15-60) Known to DHS, 1997-2003



Source: PWDRT data, n=563

Criminal Courts

PWDRT began collecting information on the criminal history of both decedents and perpetrators in 1997, including information about the age of first arrest, total number of juvenile and adult arrests, types of crime (e.g., theft, assault, illegal firearms, or drugs) and outcome of the charges (e.g., probation, incarceration, or charges withdrawn).

Many of the victims and perpetrators involved in cases of violent deaths reviewed by PWDRT had a personal and/or family history of violence and delinquency. For instance,

37 percent of perpetrators (n=99) and 26 percent of decedents (n=696) had a criminal history of prior arrests.

Both juvenile and adult criminal courts can be an important point of intervention by mandating participation in programs such as drug and alcohol counseling and anger management courses.

Family Court, PFA Unit

PWDRT began collecting information on decedent involvement with Philadelphia Family Court Protection From Abuse Orders in 1997. Protection From Abuse orders (PFAs) direct the defendant to stay away from the victim (at home, work, or school), refrain from abusing, threatening, stalking, or harassing the victim, and turn weapons over to the police (Women's Law Project, 2005).

In 2003, PWDRT began collecting more detailed information, beginning with 2001 data, from the Family Court's PFA unit, including total number of family court cases and Final Order date. PFA filings may be able to add to the Team's understanding of the decedent's role as either a victim or perpetrator in domestic and/or intimate partner violence, helping to pinpoint when a relationship has escalated to life-threatening status. While a PFA cannot prevent all future harm, the act of filing for a PFA is a signal that a woman is likely at elevated risk for violence.

Between 1997 and 2003, PWDRT found that at least 195 (7%) of the women reviewed were known to Family Court. Forty-seven (24%) of these women received one or more Final PFAs[21], 15 (1%) received one or more temporary PFAs, and 14 (1%) received one or more emergency PFAs.

Office of Emergency Shelter & Services

PWDRT began collecting information on decedent usage of OESS in 1997. OESS provides a network of shelters and housing for individuals and families, as well as outreach services, food distribution, and transitional housing. Between 1997 and 2003, 87 (3%) PWDRT women accessed OESS services.

Domestic violence is consistently cited among the primary causes for homelessness; many women leaving an abusive relationship have nowhere to go (National Coalition for the Homeless, 2005). Furthermore, when they are homeless, women are at increased risk for experiencing violence, especially while engaging in subsistence services such as the sex trade and panhandling (Wenzel et al, 2001).

[21] Once a petition for a PFA has been filed, a judge reviews the petition to determine whether the petition requires a hearing. If so, a temporary order is issued in the interim between the filing and the hearing (usually 10 days or less). The judge then listens to both parties at the hearing and decides whether or not to grant a final PFA, which can be issued for up to 18 months. If the petitioner reconciles with the abuser and allows him/her back into the petitioner's home, the PFA order could be invalidated (Women's Law Project, 2005).

Philadelphia Department of Public Health

PWDRT began collecting information on decedent usage of the city Health Centers in 2003. This information is useful in identifying risk behaviors by examining diagnoses (i.e., sexually transmitted diseases), determining family planning and prenatal care usage, and uncovering preexisting health conditions that may have contributed to the decedent's death. Between 1997 and 2003, at least 118 (4%) decedents accessed the city Health Centers.

Women in Transition (WIT)

WIT provides women with free domestic violence and substance abuse services, including a 24-hour hotline, information and referrals, counseling, and advocacy, so that they can make positive changes in their lives. PWDRT began collecting information on WIT involvement in 1997. Between 1997 and 2003, at least 33 (1%) PWDRT decedents accessed WIT.

Women Organized Against Rape (WOAR)

WOAR provides sexual assault counseling and advocacy services. PWDRT began collecting information on decedent involvement with WOAR beginning in 1997. Between 1997 and 2003, 21 (1%) PWDRT women accessed WOAR services. In this same time period, rape kits were performed on at least 73 of the decedents, and 16 women were found by the Medical Examiner to have been sexually assaulted at or shortly before the time of their death.

Chapter 10. Policy Recommendations

Recommendations

Through the review process and ongoing meetings of the Policy Committee, PWDRT continues to identify gaps in the systems that serve women in Philadelphia. The following are recommendations from the Philadelphia Women's Death Review Team based on a review of data from 1997 though 2003 and are directed toward the larger Philadelphia community of service providers and advocates.[22]

INTIMATE PARTNER VIOLENCE

In Philadelphia, between 1997 and 2003, 110 women are known to have died directly as a result of intimate partner violence. During these years, intimate partner homicides account for 40 percent of all homicides to Philadelphia women ages 15 to 60 (see page 19, for more information on IPV).

PWDRT recommends that existing efforts be expanded so that the women experiencing interpersonal violence can be reached at earlier stages of, or prior to, abuse.[23]

- Develop citywide domestic violence prevention efforts under the leadership of the Mayor that encourage neighbor-to-neighbor networking to reduce isolation and promote community vitality (i.e., Safer Streets – Safer Homes).
- Promote the availability of domestic violence counselors from the advocacy community to be co-located at the PFA filing unit of the Philadelphia Family Court to routinely provide safety planning, information and support to all individuals petitioning the court for protection from abuse and to provide follow-up and outreach services for those whose cases are dismissed through failure to prosecute.
- Strengthen community resources, including emergency shelter space, counseling, and legal advocacy, for those victimized by intimate partner violence.

[22] These recommendations must be viewed within the context of social, economic and community conditions confronting individuals and families. Poverty and low socioeconomic status are often recognized as root causes of violence, though the following recommendations do not focus on these underlying issues. However, increased economic opportunities and continuing education programs for women in neighborhoods at or below the poverty level are critical.

[23] Existing efforts include the City of Philadelphia and the four Domestic Violence Agencies launch of the Philadelphia Domestic Violence Hotline, as well as the Domestic Violence Task Force convened by the Mayor.

- Provide anti-violence education through advocacy agencies for women, girls and other populations vulnerable to gender-based violence.
- Implement a comprehensive training program for Probation/Parole staff on issues including: Domestic Violence; Post Traumatic Stress Disorder; Sex Worker issues; and Women and Addiction.
- Adopt a written protocol through the Family Court Administrative Judge to enable court accompaniment by community advocates and support networks to reduce intimidation and ensure safety in the court process.
- Promote increased awareness of intimate partner violence among private and public health clinicians and behavioral health providers through teaching hospitals, medical schools and professional medical societies.
- Develop an integrated information system and protocol among Family Court, Criminal Court and law enforcement agencies to identify cases at high risk for violence (i.e., cases where there has been frequent PFA petitions and child custody actions).

PWDRT recommends that every effort be made to increase intervention resources for those individuals who are abusive and commit acts of violence against women and girls.

- Increase the availability of intervention services for abusers by engaging those service providers already working with this population (Menergy, Men's Resource Center) to develop partnerships or additional resources through linkages with community groups (Men United for a Better Philadelphia and fatherhood initiatives) and city agencies such as men's drug treatment centers, mental health providers and prison programs.
- Develop a pilot collaboration between probation officers and the Philadelphia Police Department regarding off-hours visits to high-risk domestic violence probationers.
- Promote judicial education, informing judges about domestic violence and intervention resources in Philadelphia to increase batterer accountability.
- Advocate for the establishment of a public/private-funding stream for batterer intervention programs.

GUN CONTROL

Between 1997 and 2003, 187 deaths reviewed by PWDRT were gun-related. Gun-related deaths represent 53 percent of homicides and seven percent of all violence-associated deaths reviewed by PWDRT. In addition, guns are also used in many violent situations to intimidate and maintain control over a victim or community (see page 51, for more information on gun-related violence).

Philadelphia has made recent changes in the area of gun control[24] and PWDRT supports these additional recommendations:

[24] Under the leadership of Mayor Street, State representatives and State senators additional resources and direction have been focused on the issue of gun use and violent crime. In the last year, several major Philadelphia programs have been announced and/or implemented: the Adolescent Violence Reduction Partnership for 10 to 15 year olds; Blueprint for a Safer Philadelphia – a 10 year community-based plan,

- Develop and support a comprehensive citywide weapons-related injury surveillance system (WRISS) to capture all weapons-related injuries (i.e., guns, knives, bats, fists).
- Promote legislation to decrease gun access, such as efforts to legislate "one gun a month" purchasing restrictions.

SUBSTANCE ABUSE

More than 1,000 of the violence-associated deaths of Philadelphia women reviewed between 1997 and 2003 were related to drugs and/or alcohol (see page 52, drug and/or alcohol-related deaths for more information). Within this context, PWDRT recommends:

- Expand the Behavioral Health Training and Education Network (BHTEN) efforts for professional training in the mental health, child welfare, education, health, homelessness and public housing systems regarding the impact of trauma and domestic violence on women and its relationship to drugs and alcohol.[25]
- Promote the inclusion of trauma-focused interventions for chemically dependent women and their children in treatment and recovery programs.
- Provide access to addiction specialists and substance abuse treatment resources for DHS workers to assist in assessing families in which there are possible substance abuse problems.

COMMERCIAL SEX WORK

From 1997 and 2003, 10 percent of the decedents reviewed by PWDRT had a known history of prostitution (n=275). Of the women with a history of prostitution who died of homicide (16%, n=45), more than half (56%, n=25) represented unsolved homicides at the time of review (see page 61, for more information on commercial sex work).

PWDRT has been committed to supporting the work of the Sex Workers Health and Safety Task Force (SWHSTF) and recommends:

- Identify a community agency to provide leadership and resources to coordinate the efforts of SWHSTF.
- Develop a protocol in the Medical Examiner's Office to conduct rape kits for all homicides and undetermined deaths of women where violence is suspected and subject those swabs to DNA analysis. This will enable the Police Department to track those persons who may have been the last person to have been with this woman when she was still alive, to identify possible witnesses or perpetrators, and to identify possible serial perpetrators.

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with the goal of eliminating juvenile homicides by 2016; an established gun court to deal with defendants found with firearms; increased penalties for crimes where guns are used; support of more detectives to investigate gun violations; expanded Youth Violence Reduction Partnership. In addition, Governor Rendell signed into law Act 66 which enacts groundbreaking improvements to Pennsylvania's Protection From Abuse Act. This important legislation includes provisions that increase the possible duration of a protection order from 18 months to three years, allow judges to order the relinquishment of all a defendant's firearms while a protection order is in place, give judges authority to order supervised probation of a defendant for indirect criminal contempt of a protection order, and mandate the extension of a protection order upon a finding of contempt for violation of the order.

[25] BHTEN has a continuing commitment to provide professional training about the impact of trauma and domestic violence on women and its relationship to drugs and/or alcohol.

Unmet Needs

PWDRT supports recommendations to:

- Increase access to low income housing for battered women and their children.
- Advocate for increased housing opportunities and community services by the Mayor's Office of Offender Re-Entry Services for women being discharged from prisons, both with and without children.
- Improve access to domestic violence-related protection and prevention services for non-English speaking women, deaf and hearing impaired women and women with disabilities.
- Develop same-sex supervision in the Probation/Parole departments for male and female offenders to promote culturally successful interactions. This is specifically relevant to substance abuse and sex worker offenders.

Access to Information and Coordination

- Increase City advocacy at the State level for funds related to domestic and intimate partner violence for victims, their children and perpetrators.
- Encourage the Police Commissioner to evaluate the benefits of establishing a Domestic Violence Unit within the Police Department, similar to the Special Victims Unit.
- Continue to support the integration of data management systems for Philadelphia Adult Probation and Parole Department and Philadelphia Department of Human Services (DHS) to improve coordination of services.
- Establish a task force in the Mayor's Office of Offender Re-Entry Services to investigate how the City can better serve the needs of the women offender population and their children to make steps in breaking the cycle of violence, addiction, crime and premature death.

PWDRT depends on information from team members representing many agencies to compile complete and accurate data. PWDRT recommends continued and extended support of the Team to improve data collection.

- Support efforts to increase access to Philadelphia Police Department records, including 911 calls from relevant informants' addresses as well as victim assistance officer and DOM Team reports.
- Improve efforts to gather consistent and reliable data on disabilities among decedents. This would be accomplished through the efforts of PWDRT team members.

Child Witnesses to Violence

Over the seven-year period, 1997 to 2003, at least 1,540 children lost their mother to a violence-related premature death. Between 2001 and 2003 at least 32 children directly witnessed the death of their mother or found her body (see page 71, for more information on child witnesses). Accordingly, there should be a coordinated effort to:

- Develop a protocol within the Police Department to automatically refer all children who have experienced the death of a parent or witnessed a traumatic event to trauma assistance services.

- Promote outreach in schools, community and family centers, and faith-based organizations for children who witness violence.
- Expand crisis treatment centers to provide appropriate trauma intervention and treatment to children under the age of five and above the age of fourteen because they remain underserved age groups.

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Appendix A – Membership List

Membership of the Philadelphia Women's Death Review Team

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Appendix B – Confidentiality Statement

Confidentiality Statement for the Philadelphia Women's Death Review Team

As a member of the Philadelphia Women's Review Team, I understand that all discussions of the Review Team are confidential. I also understand that all materials reviewed or obtained by me as a member of the Review Team are confidential. There will be no follow back to families or next of kin for purposes of this fatality review, and any discussions or conclusions with people outside the Team will be in aggregate form only. Any presentation of case illustrations will have all identifiable characteristics removed. Investigation of cases by individual team members based on information obtained through the review is prohibited. I will store all materials with identifying information in a locked and secure setting, and theses materials will be disposed of by shredding or by confidential recycling when the work on the case is complete.

Print Name: _____

Organization: _____

Address: _____

_____

Telephone: _____

Fax: _____

Email: _____

Signature: _____ Date: _____

Appendix C – Data Collection Form

PHILADELPHIA WOMEN'S DEATH REVIEW TEAM
DATA COLLECTION FORM

Death Certificate Information

Review Date: (MM/DD/YY)_____
1. MEO#: _____
2. Last Name: _____
3. First Name: _____
4. Alias: _____
5. Name of Spouse: _____
6. Age: _____
7. Sex: 1. Male 2. Female
8. Gender identity:
1. Known 2. Suspected 3. Unknown
8a.Identification:
1. Man 2. Woman
9.Sexual attraction(orientation):
1. Known 2. Suspected 3. Unknown
9a. (orientation):
a. heterosexual b. lesbian
c. gay c. bisexual
d. questioning
10. DOB: _____
11.Country of birth if not USA:_____
12. DOD: _____
13. Address: **(place of residence)**
Street: _____
City: _____
State: _____
Zip: _____
14. Religion: _____
16. Ethnicity:
1. Hispanic 2. Non-Hispanic
17. Race:
1. Caucasian 4. Native Am.
2. Black 98. Other
3. Asian 99. Unknown
18. Marital Status:
1. Never Married 4. Divorced
2. Married 5. Widowed
3. Separated 99. Unknown
19. Relationship status
1. Single
2. Same sex domestic partnership
3. Opposite sex domestic partnership
20. Employed?
1. Yes 99. Unknown
2. No
21. Place of employment:_____
22. Education level:
1. Less than H.S. 4. Post H.S.
2. Some H.S. 98.Other _____
3. H.S. graduate 99. Unknown
23. Highest grade completed:_____
24. Manner of Death:
1. Natural 4. Homicide
2. Accidental 5. Undetermined
3. Suicide 6. Pending
25. Place of Death: _____
26. Reason for Review:
☐ AIDS/HIV
☐ Effects of long-term D/A abuse
☐ Adverse effect of drug(s)
☐ Questionable circumstances
☐ Homicide
☐ Suicide
☐ Pregnancy Associated
☐ Other
27. Primary cause of death (as listed on certificate): _____
28. Underlying cause of death (as listed on certificate): _____
29. Contributing factors of Death:
_____
30. Address of Event:
Street: _____
City: _____
State: _____
Zip: _____
31. Date of event: _____
32. Approx. time of event:_____
33. Certifier:
☐ MD
☐ ME
34. Autopsy performed?
1. Yes
2. No
99. Unknown
35. Was there a problem with the death cert?
1. Yes
2. No
99. Unknown
36. Problem with death certificate:
☐ Manner ☐ Certifier
☐ Cause☐ Not applicable
☐ Circumstance ☐ Other
37. Was there a death scene investigation?:
1. Yes
2. No
3. Unknown
38. Death known from:
☐ Death certificate
☐ PA Health Dept
☐ MEO
☐ DA's office

MEO

39. Place of event:

1. Highway/street
2. Own residence
3. Other residence
5. Victim's workplace
6. Bar/club/tavern
7. Recreation area
10. Vehicle
12. Restaurant
13. Child care
14. Hosp./N. home
16 Train tracks
98. Other
99. Unknown

40. If a residence, was it a known drug house?

☐

41. Evidence of prior body related injury?

☐

42. Comorbidities:

Physical	Mental
☐ Asthma	☐. Anxiety disorder
☐ Cancer	☐ Mood disorder
☐ Diabetes	☐ Cognitive disorder
☐ Heart disease	☐ Schizophrenia
☐ HIV/AIDS	☐ D/A disorder
☐ Seizures	☐ Other: _____
☐ Hypertension	
☐ Hepatitis	
☐ Obesity	

43. Was there a toxicology investigation?

☐

44. Toxicology findings:

1. Alcohol
2. Drugs
3. Both
4. None
5. Positive, b/c of hospital/EMS meds or prescription meds at appropriate dosage

45. Drug type(s):

☐Anti-convulsants	☐ Sleeping pills
☐Controlled Substnc.	☐ Other:_____
☐Anti-depressants	☐ Pain meds
☐ Antipsychotics	☐ Illicit substance

46. If yes, illicit substance, which:

☐ Marijuana	☐ Amphetamines
☐ Crack/Cocaine	☐ Sedatives/hypnotics
☐ Heroin	☐ Hallucinogens
☐ Benzos	☐ Other

47. Decedent pregnant at time of death?

1. Yes
2. No
99. Unknown

48. Weeks gestation: _____

49. Decedent pregnant in the yr before death?

1. Yes
2. No
99. Unknown

50. Was a rape kit performed/smear and swabs taken?

1. Yes
2. No
99. Unknown

51. Evidence of recent sexual activity?

1. Prob. Rape
2. Prob. Consensual
3. No
99. Unknown

52. Type of weapon/means used (check all that apply):

☐ shotgun	☐ drowning
☐ rifle	☐ poisoning by gas
☐ knife	☐ Belt/strangulate
☐ fists/hands/feet	☐ Gun type unkn
☐ fire	☐ Blunt force object
☐ poison (drug)	☐ handgun
☐ hang/suffocation	☐. Other
☐ jumping	☐ Unknown
☐ electrocution	

53. How was the homicide classified by police?

1. M Job
2. S Job
99. Unknown

Contact with Service Agencies

54. Decedent known to DHS prior to her death?

1. as a child 4. not known
2. as a parent 98. as other
3. as both 99. unknown

54a. Year the DHS first got involved:_____

55. Were there prior reports of abuse?

1. Yes 98. Other
2. No 99. Unknown

55a. # of substantiated _____

55b. # of unsubstantiated _____

56. What was the nature of DHS involvement? (Check all that apply)

☐ Investigation/assessment services of Child Protective Services or General Protective Services reports
☐ In home services child protection (SCOH)
☐ Prevention Services
☐ Dependent placement services
☐ Delinquent placement services

57. Was this an active file?

☐

58. If active, was DHS notified of decedent death?

1. Yes
2. No
99. Unknown

59. Date file closed: _____:

60. Did decedent have living children (< 18)?

1. Yes
2. No
99. Unknown

61. Total number of living children _____

62. Were children placed as a result of this death?

1. Yes
2. No
99. Unknown

If yes, with whom? _____

63. Decedent (D)/Family (F) history:

1. Diagnosis/treatment for mh/mr	D	F
4. Vict. child abuse/neglect-phys.	D	F
5. Vict. child abuse- sexual	D	F
7. Perp child abuse/neglect	D	F
18. Prior reports to PD sex. assault	D	F
8. Hist/Treat for substance abuse	D	F
9. Prior arrests/dispositions/convict.	D	F
)C15. Homeless – ever	D	F
17. Lost friend/family to violence	D	F
13. CBO contact	D	F
14. Homeless – currently	D	F
19. History of prostitution	D	F
20. Victim of DV	D	F
21. Perpetrator of DV	D	F

64. Decedent received services/in contact with:

3. Lutheran Settlement House	Y	N
4. Congreso	Y	N
5. Women In Transition	Y	N
6. WAA legal Center	Y	N
7. WOAR	Y	N
8. Community legal services	Y	N
9. Other agency	Y	N
10. WAA shelter/hotline	Y	N
11. Emergency Shelter Svc (OESS)	Y	N
12. Comm Behavioral Health (CBH)	Y	N
13. Office Mental Health (OMH)	Y	N
14. Health Department	Y	N
15. Criminal Courts	Y	N

CRIMINAL JUSTICE

General / Homicide

65. Was the homicide random?
1. Yes
2. No
3. Unknown

66. Has the perpetrator(s) been identified?
1. Yes
2. No
99. Unknown

67. Number of perpetrators:_____

68. Relationship of Perpetrator to victim:

1. Parent / guardian	10. Stranger
3. Spouse / paramour	14. Other relative
4. Ex-partner	15. Children
7. Friend	98. Other
8. Acquaintance	99. Unknown

69. Circumstances:

1. IPV	5. Crossfire
2. Felony (other)	6. Argument general
3. Arson	98. Other
4. Gang activity	99. Unknown

70. Motive:

1. Argument (general)	5. self-defense
2. decedent ending relationship	6. Drug-related
3. Retaliation	98. Other
4. Custody battle	99. Unknown

71. Other persons/victims injured?
1. Yes
2. No
99. Unknown

72. How many?_____

73. Legal status with justice system at time of event

1. Bench warrant	5. Incarcerated
2. Probation/parole	6. Open case
3. Arrest warrant	7. No record
4. Completed	8. Unknown

74. Decedent Adult record:

Charge	#arrests	#convict	#incarc	#probat
Drug-related				
Property				
Prostitution				
Sex Offenses				
Theft				
Violence				
Weapons				
Other				

75. Children witness the death or find the body?
1. Yes
2. No
99. Unknown

76. Were services provided to child witnesses?
1. Yes
2. No
99. Unknown

77 Was the Trauma Referral Hotline Contacted?
1. Yes
2. No
99. Unknown

78. Calls made to 911 in year prior to death?
1. Yes
2. No
99. Unknown

79. Was the homicide classified an M or an S job by the PD?
1. M job
2. S job
99. Unknown

Suicide

80. Previous suicide attempts?
1. Yes
2. No
99. Unknown

81. Number of previous suicide attempts: ___

82. Was suicide note left?
1. Yes
2. No
99. Unknown

Perpetrator Information

83. Did decedent live with perpetrator in year prior to death?

1. Full time
2. Part time
3. Both
4. Not at all
99. Unknown

84. Was the perpetrator the father of decedent's children?

1. Yes
2. No
99. Unknown

85. Name: _____

86. Address: _____

87. City: _____ **88. State:** _____

89. Zip: _____ **90. Age:** _____

91. Gender:

1. Male
2. Female
99. Unknown

92. Race:

1. Caucasian
2. Af.-American
3. Asian
4. Native American
98. Other
99. Unknown

93. Ethnicity:

1. Hispanic
2. Non-Hispanic

94. Has child/children in his/her custody?

1. Yes
2. No
99. Unknown

95. On disability?

1. Yes
2. No
99. Unknown

96. Employed:

1. Yes
2. No
99. Unknown

97. Toxicology investigation performed?

1. Yes
2. No
99. Unknown

98. Toxicology findings:

1. Alcohol
2. Drugs
3. Both
4. None

99. Drug type:

1. Anti-convulsants
2. Anti-depressants
3. Anti-psychotics
4. Controlled substance
5. Sleeping pills
6. Pain meds
7. Illicit substance
8. Other: _____

100. Did perpetrator commit suicide?

1. Yes
2. Attempted
3. No
99. Unknown

101. Perpetrator (P)/Family(F) History:

1. Diagnosis/treatmnt for mh/mr	P	F
4. Vict. child abuse/neglect-phys.	P	F
5. Vict. child abuse- sexual	P	F
7. Perp child abuse/neglect	P	F
18. Prior reports to PD sex. assault	P	F
6. Prior reports DHS child abuse/neglect	P	F
8. Treatment for substance abuse	P	F
9. Prior arrest/disposit/convict.	P	F
10. Contributing medical problems	P	F
12. Employment problems	P	F
) 15. Homeless – ever	P	F
16. Frequent moves	P	F
19. Lost friend/family to violence	P	F
13. CBO contact	P	F
14. Homeless – currently	P	F
-- . History of prostitution	P	F ro

102. At time of event, perp. current legal status:

1. Bench warrant
2. Probation/parole
3. Arrest warrant
4. Completed
5. Incarcerated
6. Open case
7. No record
99. Unknown

103. Perpetrator Adult record:

Charge	#arrests	#convict	#incarc	#probat
Drug-related				
Property				
Prostitution				
Sex Offenses				
Theft				
Violence				
Weapons				
Other				

104. Perpetrator juvenile record:

Charge	#arrests	#convict	#incarc	#probat
Drug-related				
Property				
Prostitution				
Sex Offenses				
Theft				
Violence				
Weapons				
Other				

Court Information

105. Was there an arrest?

1. Yes
2. No

99. Unknown

106. Criminal charges pursued by prosecutor?

1. Yes
2. No

99. Unknown

107. court activities: _____

FAMILY COURT INFORMATION

108. Was the decedent known to Family Court?

1. Yes
2. No

99. Unknown

109. In how many cases was the decent known to Family Court? _____

Family Court Cases:

Date	**Decedent was:**	**Result**	**If Final Order, date of entry**
1.	1. Plaintiff 2. Defendant 3. Both	1. Dismissed for lack of prosecution 2. Final Order entered 3. Active at time of death 4. Other _____ 99. Unknown	
2.	1. Plaintiff 2. Defendant 3. Both	1. Dismissed for lack of prosecution 2. Final Order entered 3. Active at time of death 4. Other _____ 99. Unknown	
3.	1. Plaintiff 2. Defendant 3. Both	1. Dismissed for lack of prosecution 2. Final Order entered 3. Active at time of death 4. Other _____ 99. Unknown	
4.	1. Plaintiff 2. Defendant 3. Both	1. Dismissed for lack of prosecution 2. Final Order entered 3. Active at time of death 4. Other _____ 99. Unknown	

SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT INFORMATION

Substance Abuse

110. Does the decedent have a substance abuse history with CBH?
1. Yes
2. No
99. Unknown

111. Was the decedent approved for SAT services?
1. Yes
2. No
99. Unknown

112. Did the decedent utilize SAT services?
1. Yes
2. No
99. Unknown

113. SA Treatment type:
☐ Outpatient
☐ Intensive outpatient
☐ Halfway
☐Non-hospital short-term res(rehab)
☐ Non-hospital long-term res (rehab)
☐ Hospital based residential tx
☐ Detoxification
☐ Unknown

114. Substance abuse diagnosis
☐ Alcohol
☐ Amphetamines
☐ Cocaine
☐ Hallucinogens
☐ Inhalants
☐ Sedatives/hypnotics
☐ Opiates
☐ Substance Dependence (Polysubstance)
☐ Marijuana

115. Date of most recent discharge fromSAT, if known: _____

116. Number of days authorized for SAT:_____

117. What type of SAT follow-up was authorized?
1. IOP
2. Outpatient
99. Unknown

118. Did the decedent comply with the SAT follow- up?
1. Yes
2. No
99. Unknown

119. Number of detox authorizations:_____

120. Number of rehab authorizations:_____

Mental Health

120. Does the decedent have a mental health history with CBH?
1. Yes
2. No
99. Unknown

121. Was the decedent approved for MH services?
1. Yes
2. No
99. Unknown

122. Did the decedent utilize MH services?
1. Yes
2. No
99. Unknown

123. MH treatment type:
☐ Inpatient ☐ Partial hospital
☐ Outpatient ☐ Residential
☐ Unknown

124. Mental health diagnosis:
☐ Depression
☐ Bipolar
☐ Schizophrenia
☐ Anxiety disorder
☐ Suicidal
☐ Other _____

125. Date of most recent discharge from mental health treatment:

_____

126. Number of days authorized for mental health treatment:

_____

127. W1hat type of MHT follow-up was authorized?
1. IOP
2. Outpatient
99. Unknown

128. Did the decedent comply with the MHT follow-up?
1. Yes
2. No
99. Unknown

SUMMATION:

- **Selected for Review?**
- **Reviewed?**
- **Family member known to PIFYRT?**
- **Info on decedent prior to death?**
- **Info on decedent from non-criminal justice agency?**
- **Info on decedent from criminal justice agency?**
- **Case to bring back?**

NOTES:

Appendix D – Death Certificate

H105.143 Rev. 2/87

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF HEALTH • VITAL RECORDS
CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

STATE FILE NUMBER

ALIAS USED

NAME OF DECEDENT

DECEDENT PERSONAL DATA

1. NAME OF DECEDENT (First, Middle, Last)	2. SEX	3. SOCIAL SECURITY NUMBER — —	4. DATE OF DEATH (Month, Day, Year)

5. AGE (Last Birthday) Yrs.	UNDER 1 YEAR Months / Days	UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Month, Day, Year)	7. BIRTHPLACE (City and State or Foreign Country)

8e. PLACE OF DEATH (Check only one — see instructions on other side)
HOSPITAL: Inpatient ☐ ER/Outpatient ☐ DOA ☐
OTHER: Nursing Home ☐ Residence ☐ Other (Specify) ☐

8b. COUNTY OF DEATH	8c. CITY, BORO, TWP OF DEATH	8d. FACILITY NAME (If not institution, give street and number)

9. WAS DECEDENT OF HISPANIC ORIGIN? No ☐ Yes ☐ If yes, specify Cuban, Mexican, Puerto Rican, etc.	10. RACE - American Indian, Black, White, etc. (Specify)

11a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life; do not use retired)	11b. KIND OF BUSINESS/INDUSTRY	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? Yes ☐ No ☐	13. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	14. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify)	15. SURVIVING SPOUSE (If wife, give maiden name)

16. DECEDENT'S MAILING ADDRESS (Street, City/Town, State, Zip Code)

DECEDENT'S ACTUAL RESIDENCE (See instructions on other side)
17a. State _____ Did decedent live in a township?
17b. County _____
17c. ☐ Yes, decedent lived in _____ twp.
17d. ☐ No, decedent lived within actual limits of _____ city/boro.

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
20a. INFORMANT'S NAME (Type/Print)	20b. INFORMANT'S MAILING ADDRESS (Street, City/Town, State, Zip Code)

DISPOSITION

21a. METHOD OF DISPOSITION Donation ☐ Burial ☐ Cremation ☐ Removal from State ☐ Other (Specify) ☐	21b. DATE OF DISPOSITION (Month, Day, Year)	21c. PLACE OF DISPOSITION - Name of Cemetery, Crematory or Other Place	21d. LOCATION - City/Town, State, Zip Code

22a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	22b. LICENSE NUMBER	22c. NAME AND ADDRESS OF FACILITY

PRONOUNCING PHYSICIAN ONLY (See definition on other side)

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death.

23a. To the best of my knowledge, death occurred at the time, date and place stated. (Signature and Title)	23b. LICENSE NUMBER	23c. DATE SIGNED (Month, Day, Year)

Items 24-26 must be completed by person who pronounces death.

24. TIME OF DEATH M.	25. DATE PRONOUNCED DEAD (Month, Day, Year)	26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? Yes ☐ No ☐

CAUSE OF DEATH (See instructions on other side)

27. **PART I:** Enter the diseases, injuries or complications which caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

		Approximate interval between onset and death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions if any, leading to immediate cause. Enter **UNDERLYING CAUSE** (Disease or injury that initiated events resulting in death) **LAST**	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II: Other significant conditions contributing to death, but not resulting in the underlying cause given in PART I.

28a. WAS AN AUTOPSY PERFORMED? Yes ☐ No ☐	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Yes ☐ No ☐	29. MANNER OF DEATH Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined ☐	30a. DATE OF INJURY (Month, Day, Year)	30b. TIME OF INJURY M.	30c. INJURY AT WORK? Yes ☐ No ☐	30d. DESCRIBE HOW INJURY OCCURRED.

30e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)	30f. LOCATION (Street, City/Town, State)

CERTIFIER (See definitions on other side)

CERTIFIER (Check only one)

*CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. ☐

*PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying to cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. ☐

*MEDICAL EXAMINER/CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. ☐

31a.

31b. SIGNATURE AND TITLE OF CERTIFIER	
31c. LICENSE NUMBER	31d. DATE SIGNED (Month, Day, Year)
32. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) Type or Print	

33. REGISTRAR'S SIGNATURE AND NUMBER	34. DATE FILED (Month, Day, Year)

Appendix E – List of Acronyms

List of Acronyms

BHTEN	Behavioral Health Training and Education Network
CBH	Community Behavioral Health
CDC	Centers for Disease Control and Prevention
DHS	Department of Human Services
DV	Domestic Violence
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
IPV	Intimate Partner Violence
IPV Homicides	Intimate Partner Violence Homicides (Homicide as a direct result of IPV)
OESS	Office of Emergency Shelter and Services
OMH	Office of Mental Health
PFA	Protection From Abuse
PHMC	Philadelphia Health Management Corporation
PWDRT	Philadelphia Women's Death Review Team
SWHSTF	Sex Workers Health and Safety Task Force
WIT	Women in Transition, Inc.
WOAR	Women Organized Against Rape
WRISS	Weapons-Related Injury Surveillance System

Other Abbreviation
"**The Team**" – Philadelphia Women's Death Review Team (PWDRT)
DOM Team – Domestic Case Team at the Police Department

Appendix F – Profile of Deaths of Philadelphia Women 1997-2003 (15-60 years of age)

Deaths Among Philadelphia Women (Ages 15 to 60), 1997-2003*

	1997		1998		1999		2000		2001		2002		2003	
Manner of Death	#	%	#	%	#	%	#	%	#	%	#	%	#	
Natural	1192	83.3%	1135	84.7%	1243	87.1%	1207	81.8%	1249	84.3%	1226	85.5%	1224	85.8%
Unintentional Injury	142	9.9%	121	9.0%	113	7.9%	154	10.4%	151	10.2%	128	9.0%	116	8.1%
Homicide	46	3.2%	48	3.6%	35	2.5%	35	2.4%	32	2.2%	31	2.2%	42	2.9%
Suicide	30	2.1%	29	2.2%	21	1.5%	29	2.0%	29	2.0%	27	1.9%	31	2.2%
Undetermined	21	1.5%	4	0.3%	15	1.1%	15	1.0%	10	0.7%	17	1.2%	14	1.0%
Race														
White	521	36.4%	515	38.4%	554	38.8%	5834	39.6%	570	38.5%	563	38.4%	583	40.4%
Black	820	57.3%	748	55.8%	834	58.4%	850	57.6%	868	58.6%	881	60.1%	851	58.9%
Asian	19	1.3%	21	1.6%	21	1.5%	3	0.2%	9	0.6%	2	.1%	1	.1%
Other/Unknown	71	5.0%	56	4.2%	18	1.3%	38	2.5%	33	2.2%	21	1.4%	9	.6%
Ethnicity														
Hispanic	65	4.5%	65	4.9%	56	3.9%	86	5.8%	78	5.3%	82	5.6%	93	6.3%
Non-Hispanic	1366	95.5%	1275	95.1%	1260	88.3%	1367	92.7%	1401	94.6%	1385	94.4%	1359	92.8%
Unknown	0	0.0%	0	0.0%	111	7.8%	22	1.5%	2	0.1%	0	0	13	..9%
Age Range														
15-19	31	2.2%	19	1.4%	14	1.0%	20	1.4%	18	1.2%	17	1.2%	21	1.4%
20-24	45	3.1%	34	2.5%	32	2.2%	29	2.0%	34	2.3%	37	2.5%	26	1.8%
25-30	54	3.8%	42	3.1%	45	3.2%	56	3.8%	39	2.6%	45	3.1%	43	2.9%
30-34	104	7.3%	76	5.7%	84	5.9%	72	4.9%	59	4.0%	60	4.1%	71	4.8%
35-39	118	8.2%	126	9.4%	139	9.7%	136	9.2%	132	8.9%	117	8.0%	117	8.0%
40-44	188	13.1%	185	13.8%	168	11.8%	179	12.1%	195	13.2%	212	14.5%	185	12.6%
45-49	242	16.9%	219	16.3%	242	17.0%	243	16.5%	234	15.8%	248	16.9%	243	16.6%
50-54	300	21.0%	281	21.0%	278	19.5%	318	21.6%	325	21.9%	299	20.4%	313	21.4%
55-60	349	24.4%	358	26.7%	425	29.8%	422	28.6%	445	30.0%	432	29.4%	446	30.4%
Total Deaths	1431	100.0%	1340	100.0%	1427	100.0%	1475	100.0%	1481	100.0%	1467	100.0%	1465	100.0%

* Data are from the Philadelphia electronic City File

Deaths Among Philadelphia Women (Ages 15 to 60), 1997-2003[1]

	1997		1998		1999		2000		2001		2002		2003	
Reason for Review of Natural Death	#	%	#	%	#	%	#	%	#	%	#	%	#	%
HIV/AIDS	72	6.0%	76	6.7%	87	7.0%	84	7.0%	70	5.6%	86	7.0%	59	4.8%
Long-term Effects of Drug/Alcohol Abuse	53	4.4%	47	4.1%	82	6.6%	94	7.8%	85	6.8%	47	3.8%	45	3.7%
Reason for Review of Unintentional Injury Deaths:														
Adverse Effects of Drugs	79	55.6%	77	63.6%	59	52.2%	105	68.2%	102	67.5%	84	65.6%	58	50.0%
Circumstance of Homicide Deaths														
Intimate Partner Violence	20	43.5%	13	27.7%	13	36.1%	12	34.3%	11	33.3%	9	29.0%	6	14.3%

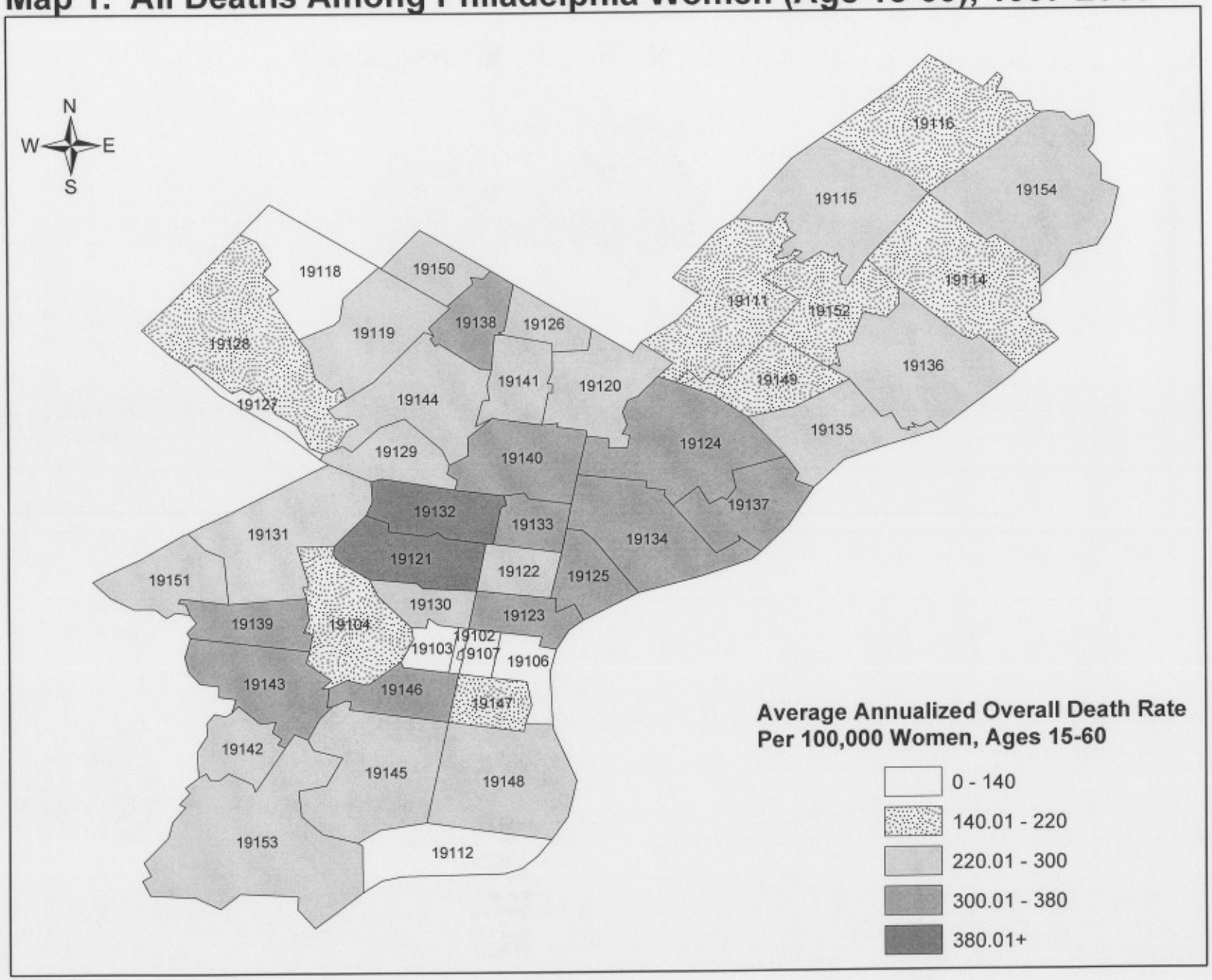
Deaths Rates Among Philadelphia Women (Ages 15 to 60), 1997-2003, By Manner of Death

Rate per 100,000 Women[2]							
Manner of Death	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
Natural	255.2	251.6	271.7	244.4	254.0	250.7	251.6
Unintentional Injury	30.4	26.8	24.8	31.2	32.1	21.7	21.0
Homicide	9.9	10.1	7.8	7.1	7.1	5.9	8.02
Suicide	6.4	6.3	4.4	5.9	6.1	5.8	6.4
Undetermined	4.5	1.1	3.0	2.8	2.0	3.5	2.9
All Deaths	306.3	288.9	310.7	298.6	301.0	287.5	289.8

[1] After further review, figures for 2000 have been updated from those appearing in the 2000 Report.
[2] Rates calculated by PHMC staff based on population estimates provided by the Vital Statistics Reports of 1997-2003, Philadelphia Department of Public Health.

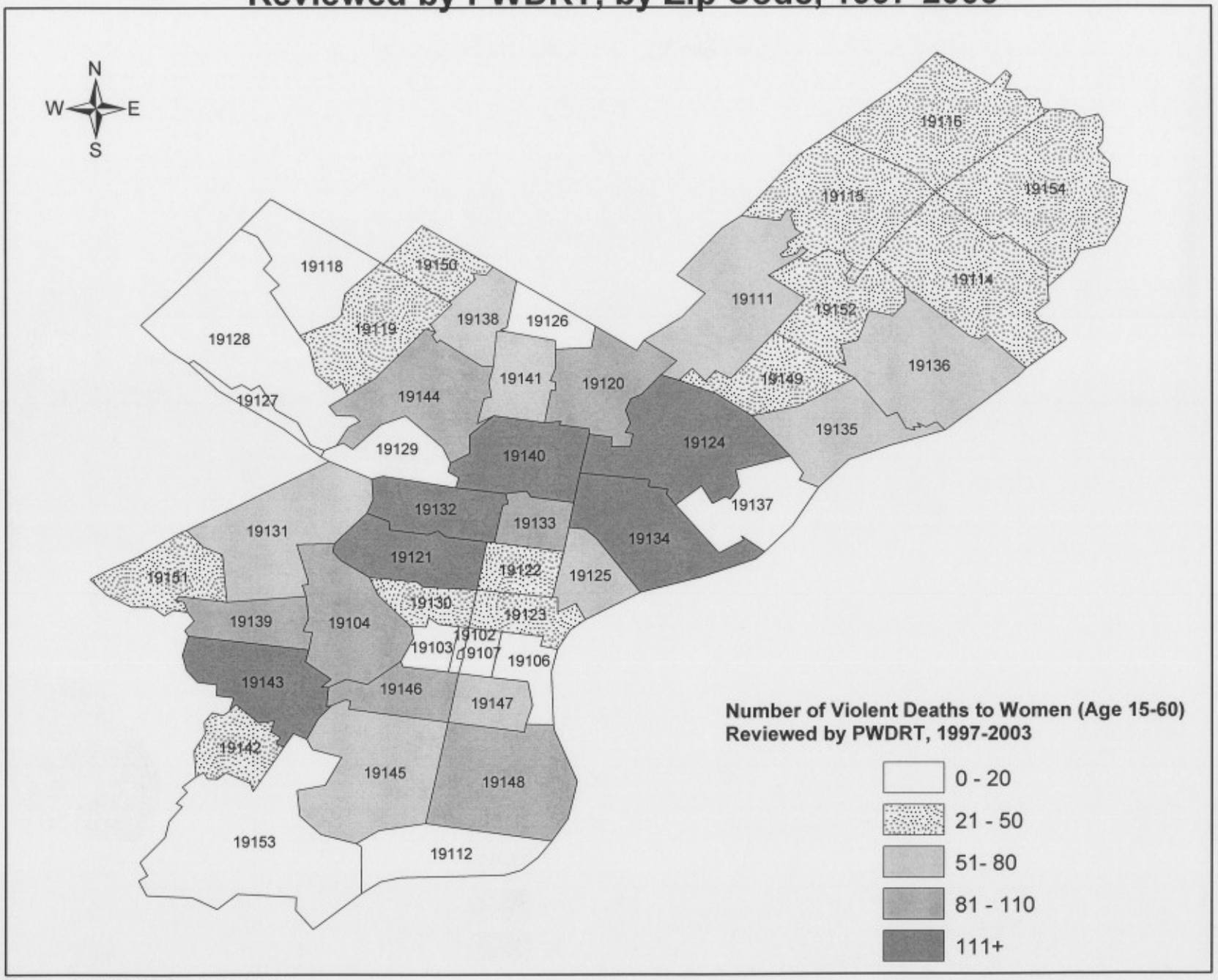
Appendix G – Maps

Map 1. All Deaths Among Philadelphia Women (Age 15-60), 1997-2003



Source: Philadelphia County Vital Statistics (n=10, 086).

Map 2. Number of Violent Deaths Among Philadelphia Women (Ages 15-60) Reviewed by PWDRT, by Zip Code, 1997-2003

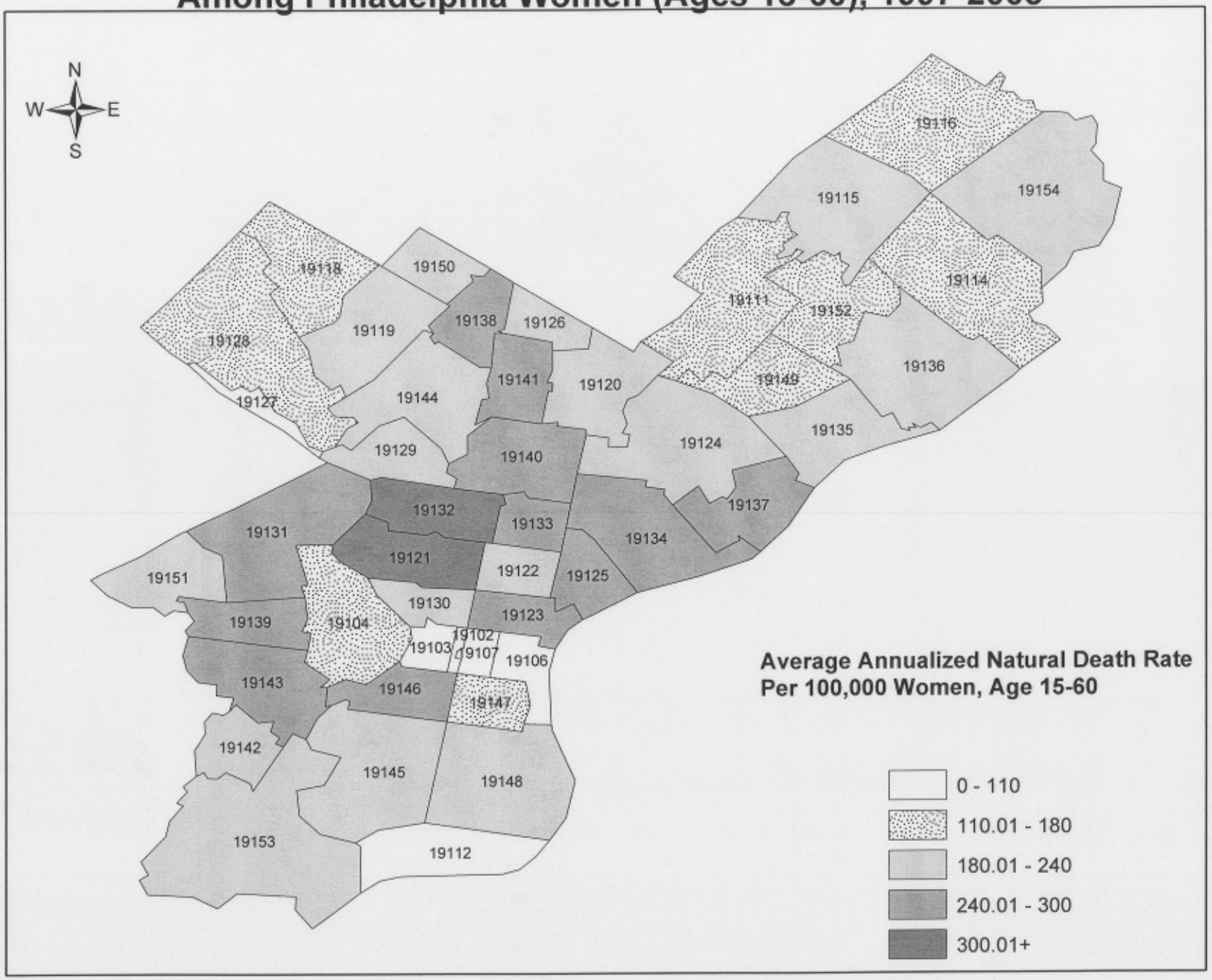


Source: PWDRT data. (n=2,630)

PWDRT reviewed the deaths of 2,630 Philadelphia women who died violence-related deaths between 1997 and 2003.

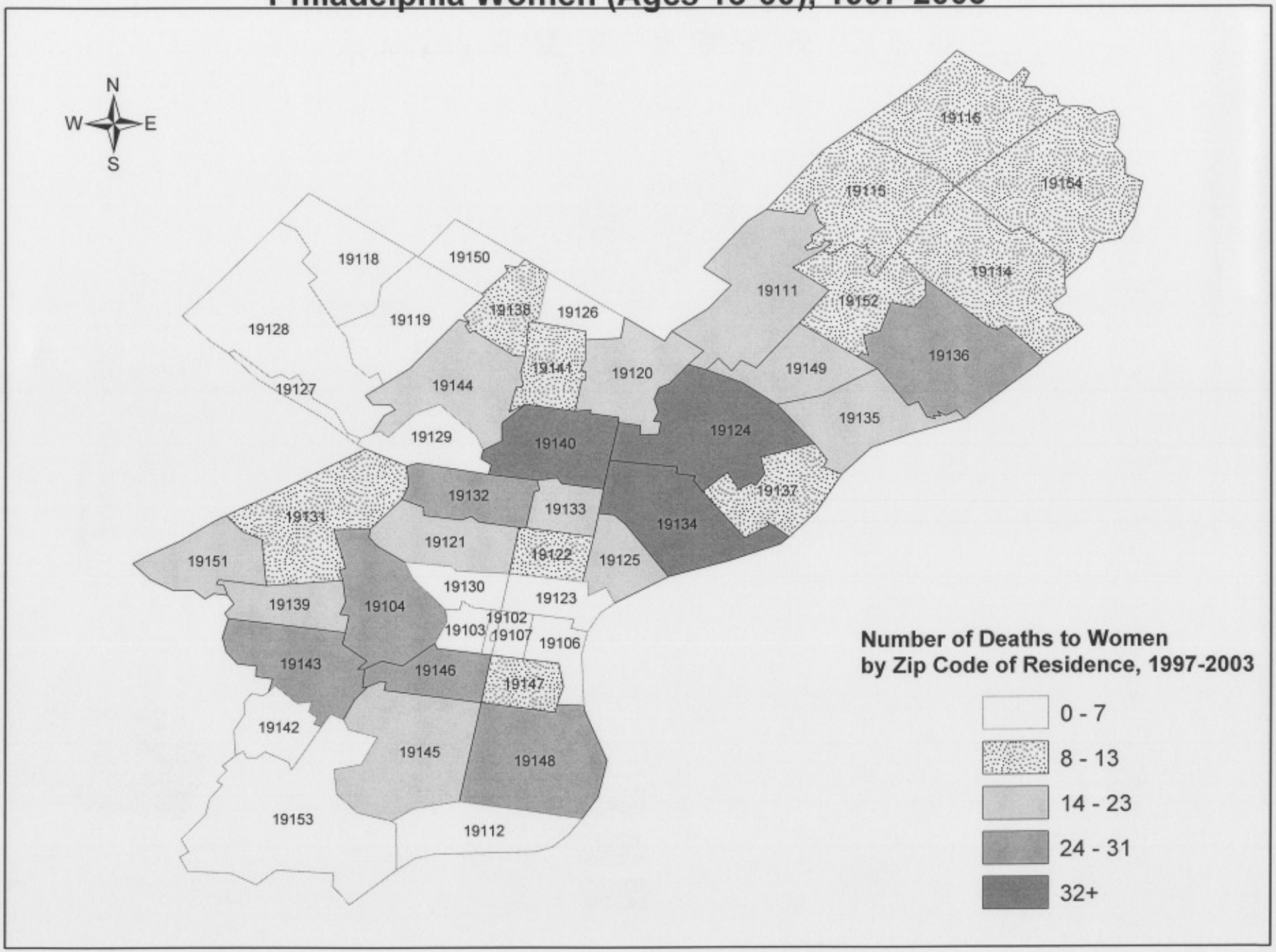
This map excludes 65 reviewed women who either had out of county residences listed on their death certificates, or their residence Zip code was unknown.

Map 3. Deaths Due to Natural Causes Among Philadelphia Women (Ages 15-60), 1997-2003



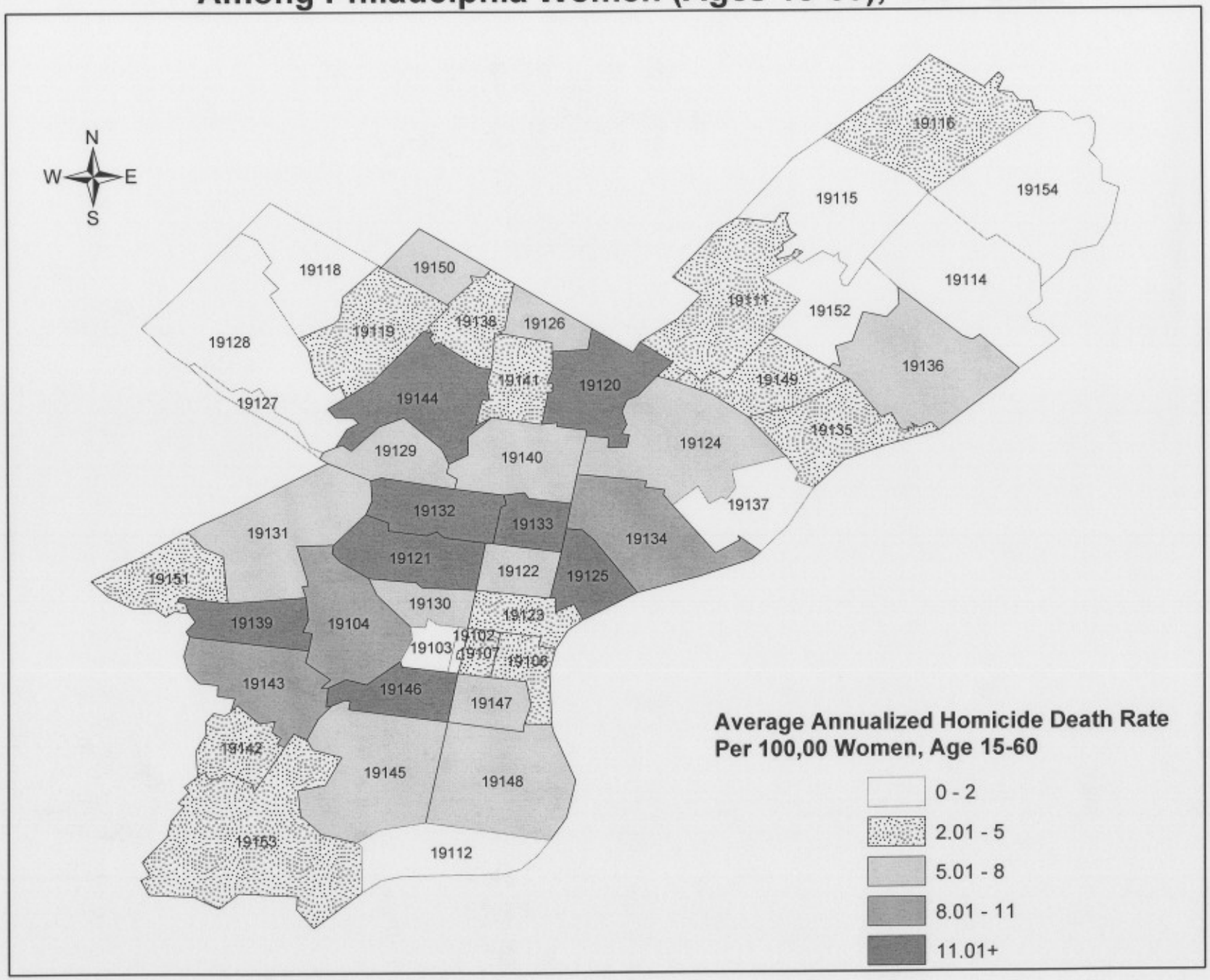
Source: Philadelphia County Vital Statistics. (n=8,476)

Map 4. Unintentional Injury Deaths Among Philadelphia Women (Ages 15-60), 1997-2003



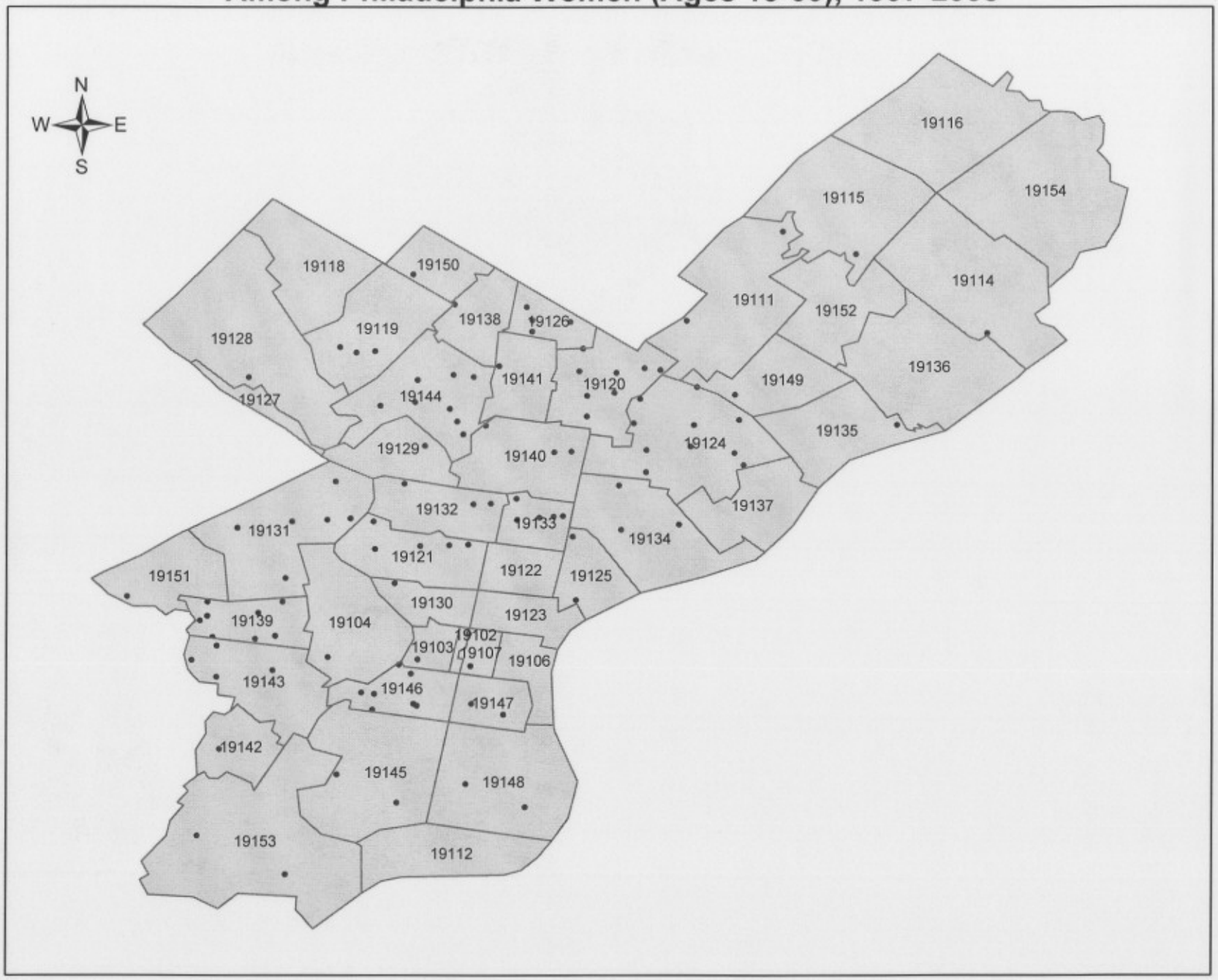
Source: PWDRT data, n=703

Map 5. Homicide Deaths
Among Philadelphia Women (Ages 15-60), 1997-2003



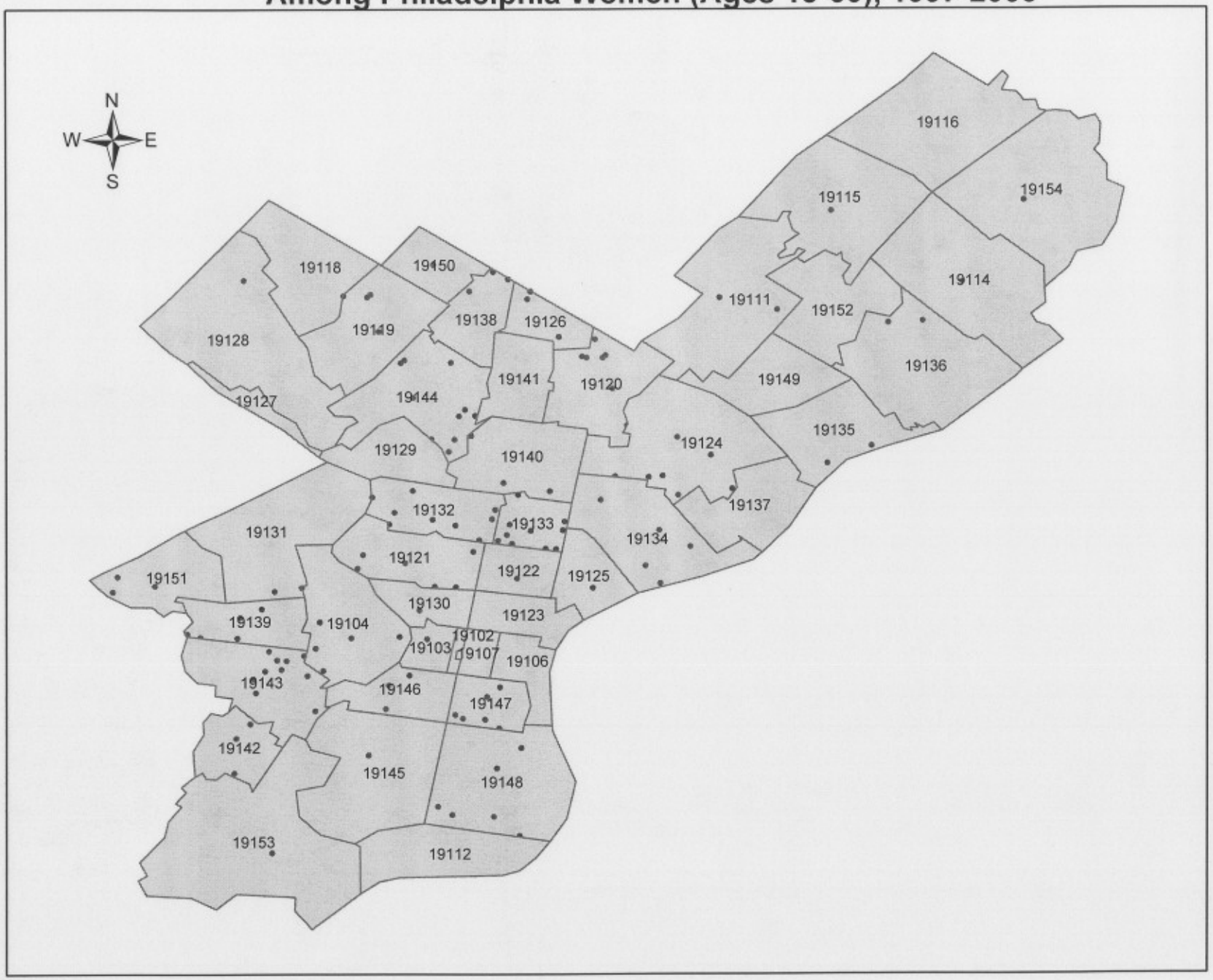
Source: Philadelphia County Vital Statistics (n=219).

Map 6. Locations of Intimate Partner Homicides Among Philadelphia Women (Ages 15-60), 1997-2003



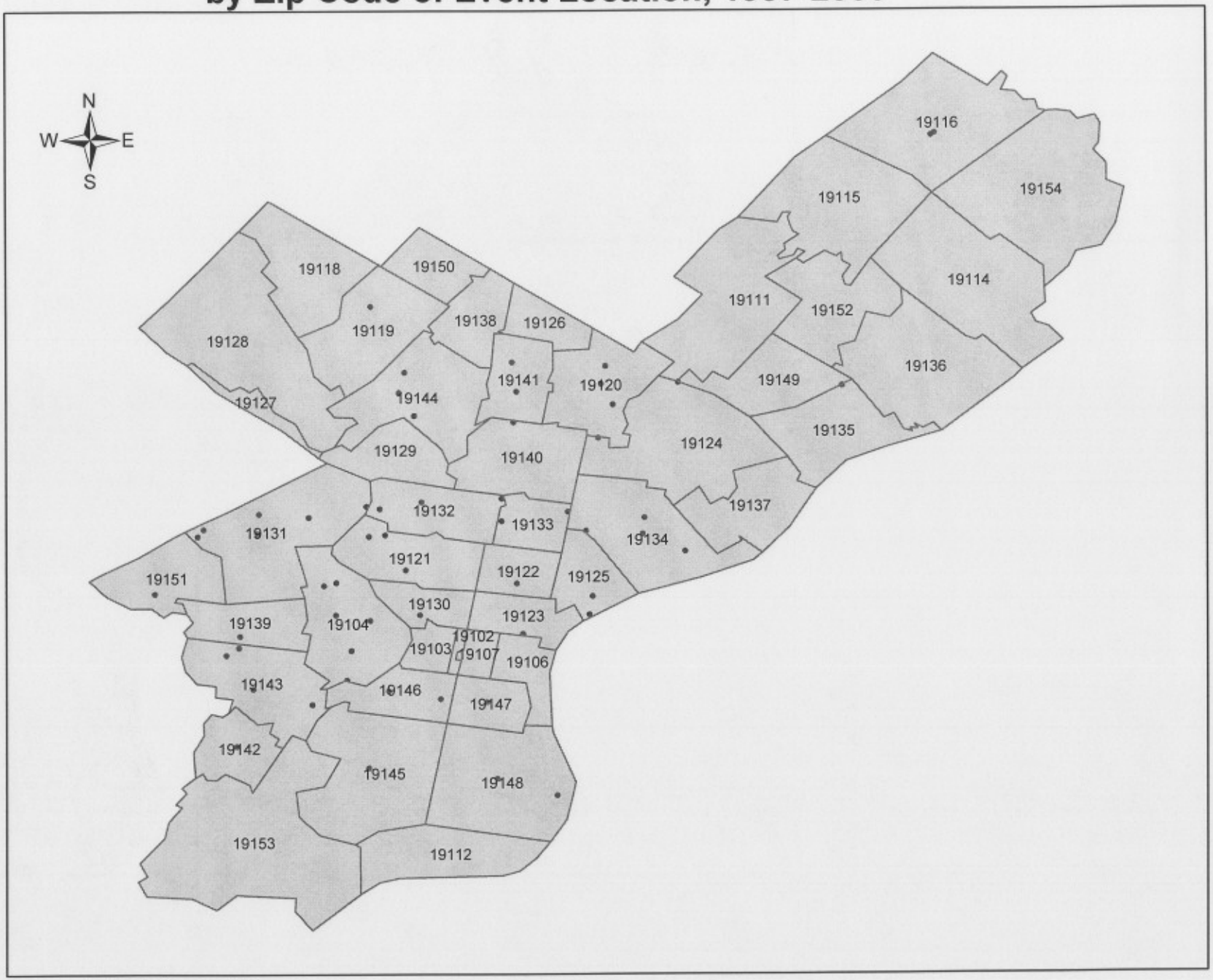
Source: PWDRT data (n=110).
Dots represent locations of Intimate Partner Homicides; more than one homicide may occur at the same location.

Map 7. Locations of Gun Homicides Among Philadelphia Women (Ages 15-60), 1997-2003



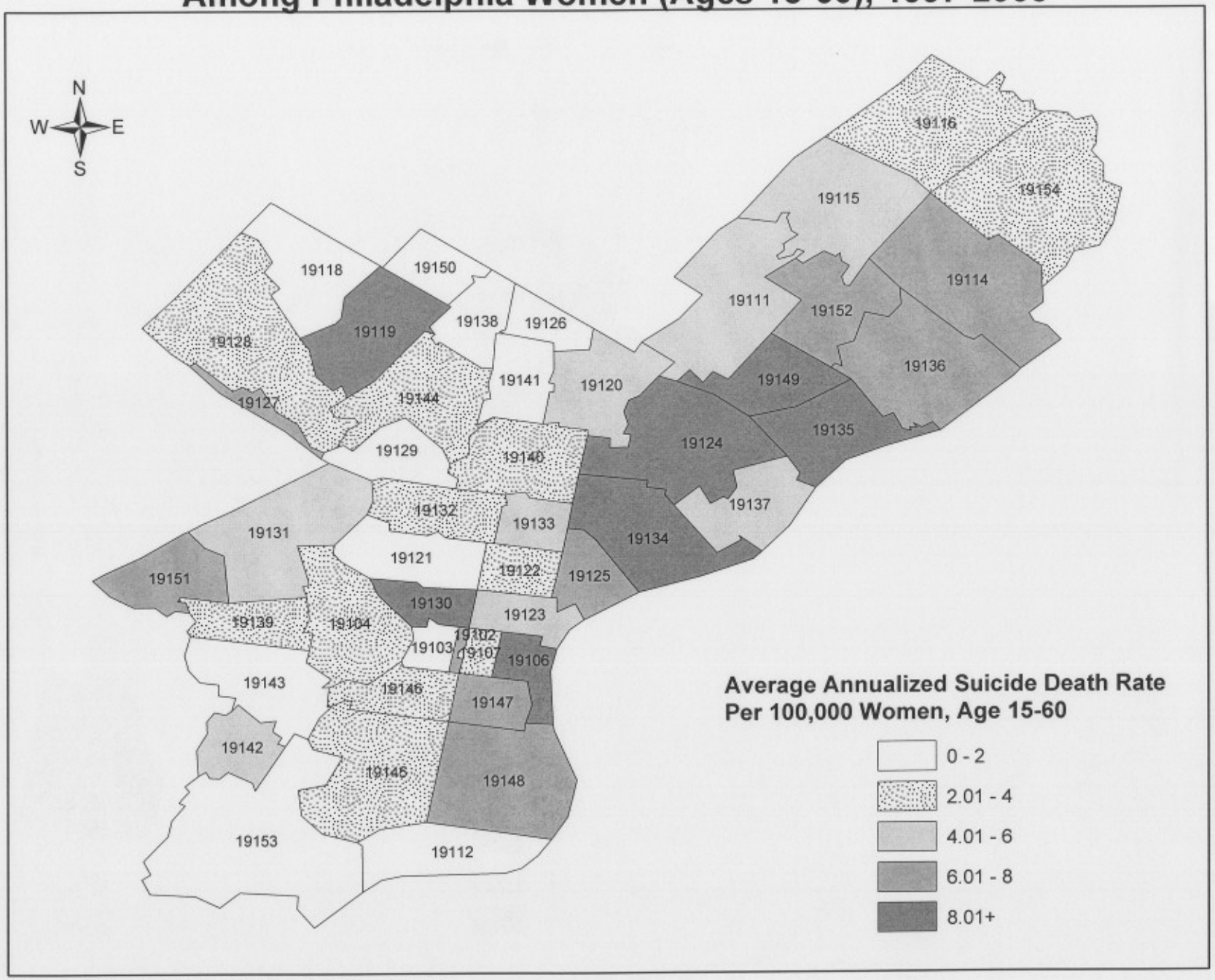
Source: PWDRT data (n=145).
Dots represent homicide locations committed with a gun. More than one homicide may occur at the same location.

Map 8. Unsolved Homicides of Philadelphia Women (Ages 15-60), by Zip Code of Event Location, 1997-2003



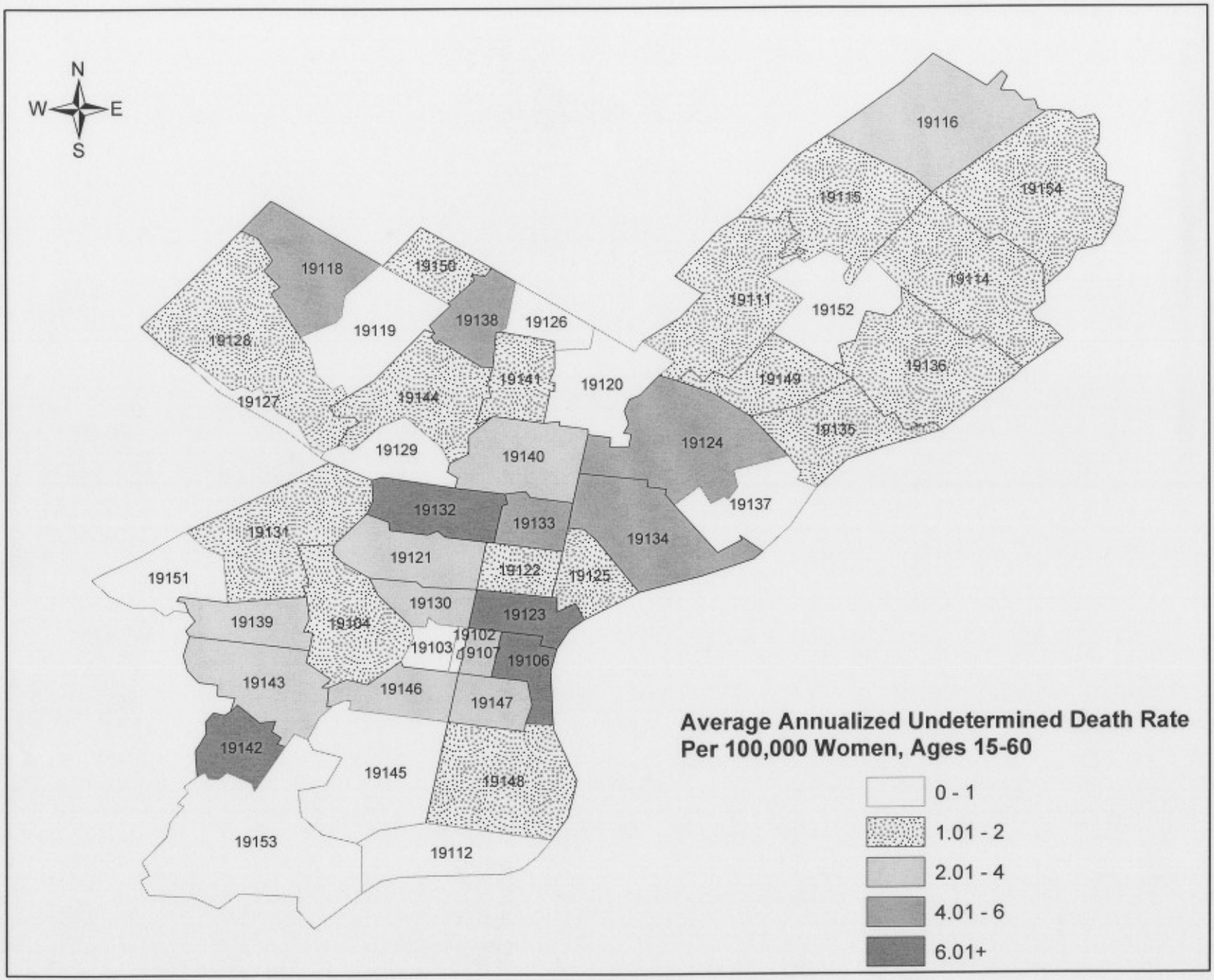
Source: PWDRT data (n=65).
Dots represent location of homicides; more than one homicide may occur at the same location.
The location of six homicides was not known.

Map 9. Suicide Deaths
Among Philadelphia Women (Ages 15-60), 1997-2003



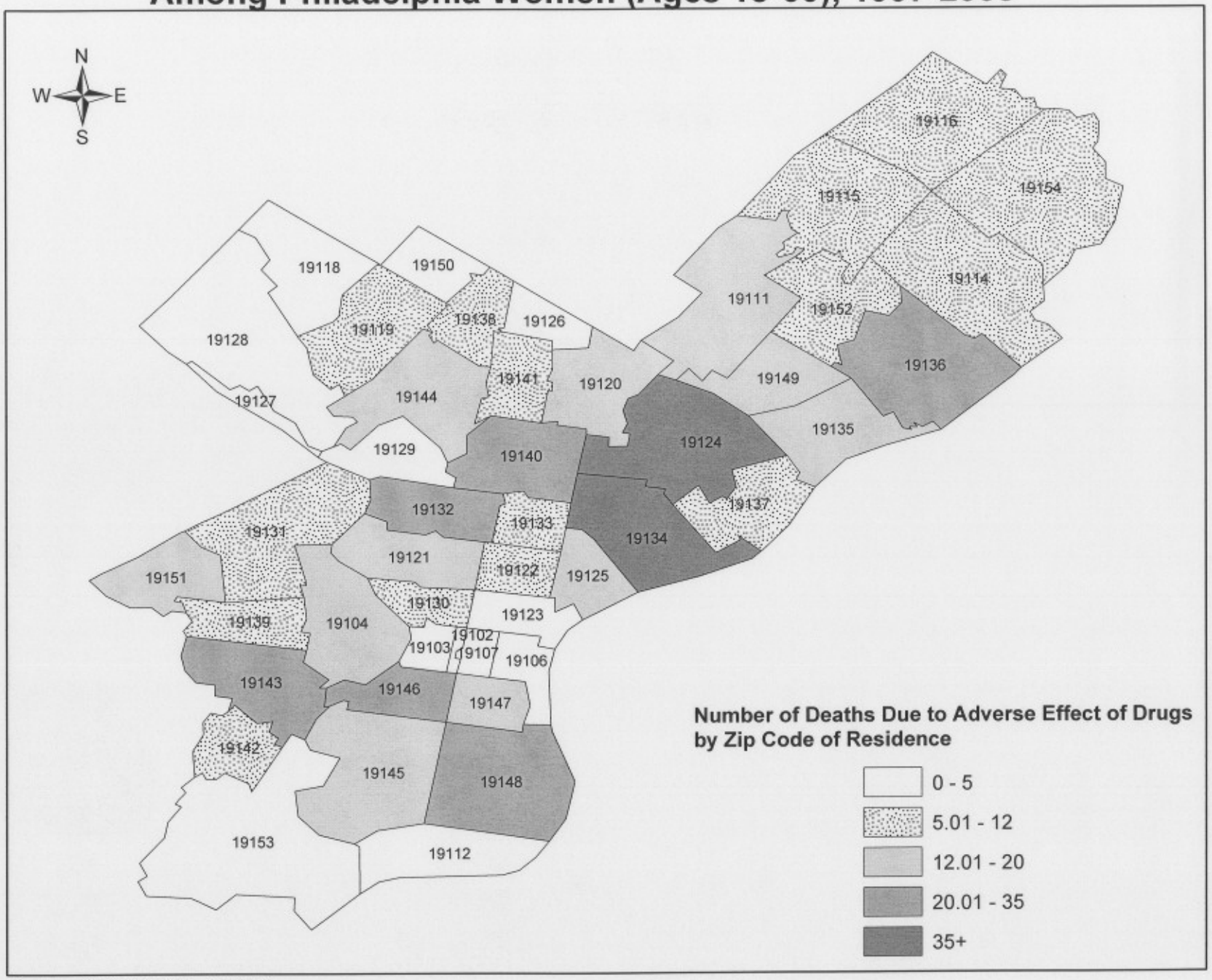
Source: Philadelphia County Vital Statistics (n=182)

Map 10. Undetermined Deaths Among Philadelphia Women (Ages 15-60), 1997-2003



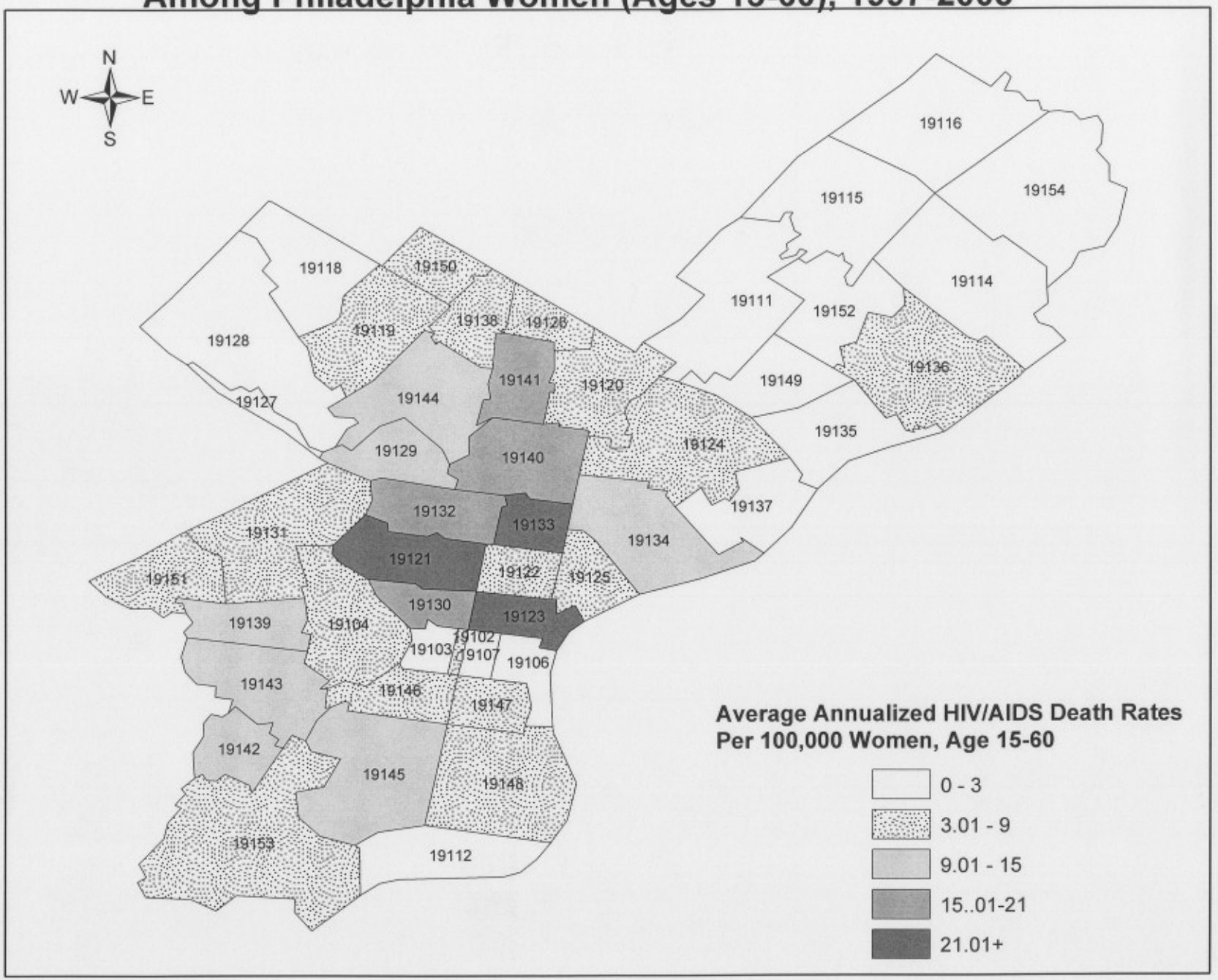
Source: PWDRT data (n=98).
A death was defined as undetermined if the Medical Examiner was unable to determine the manner of death at the time the death certificate was completed.

Map 11. Deaths Due to Adverse Effect of Drugs Among Philadelphia Women (Ages 15-60), 1997-2003



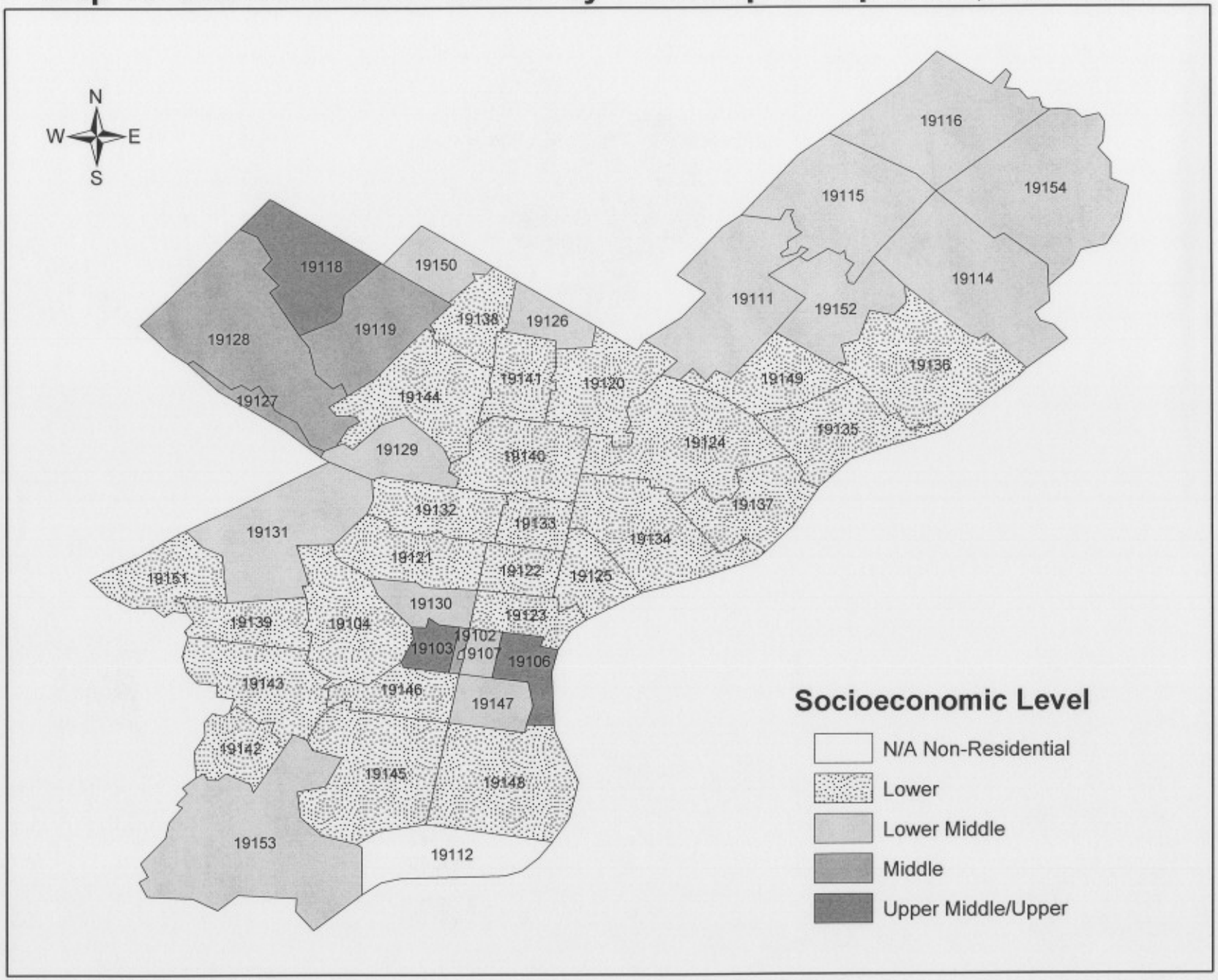
Source: PWDRT data, (n=611).
In 19 cases, the decedent's Philadelphia residence was unknown, and is therefore not included in this map.

Map 12. HIV/AIDS Deaths
Among Philadelphia Women (Ages 15-60), 1997-2003



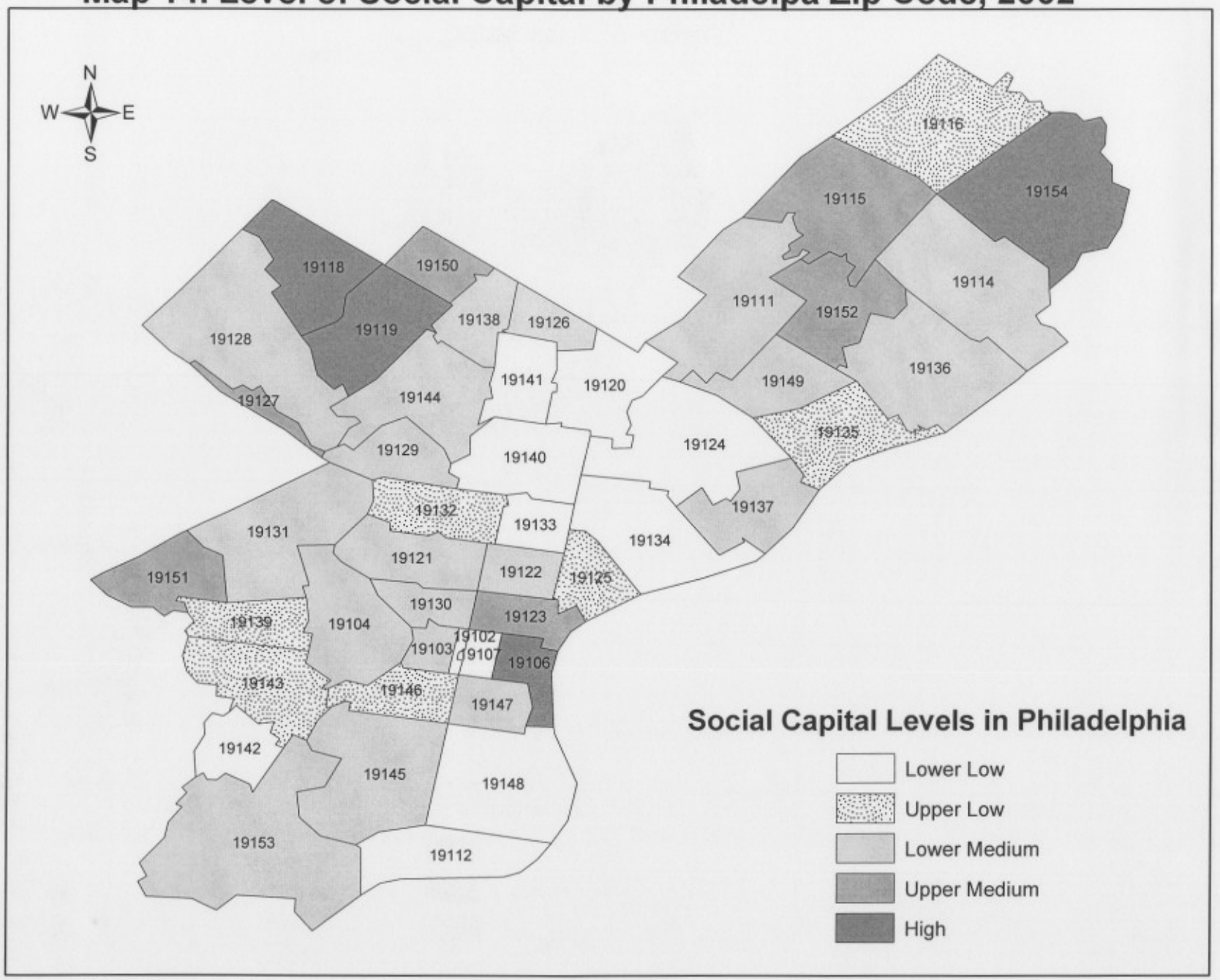
Source: Philadelphia County Vital Statistics (n=343).

Map 13. Socioeconomic Levels by Philadelphia Zip Code,1997-2003



Source: Philadelphia 2000 Census
Socioeconomic status measures per capita income, median household income, percentage of college graduates and percentage of professionals in a given census tract

Map 14. Level of Social Capital by Philadelpa Zip Code, 2002



Source: PHMC Community Health Database's Household Health Survey, 2002

Social Capital is a measure of community connectedness based on the elements of civic participation, sense of community belonging, trust in neighbors, belief that neighbors look out for one another, and efforts to improve the neighborhood