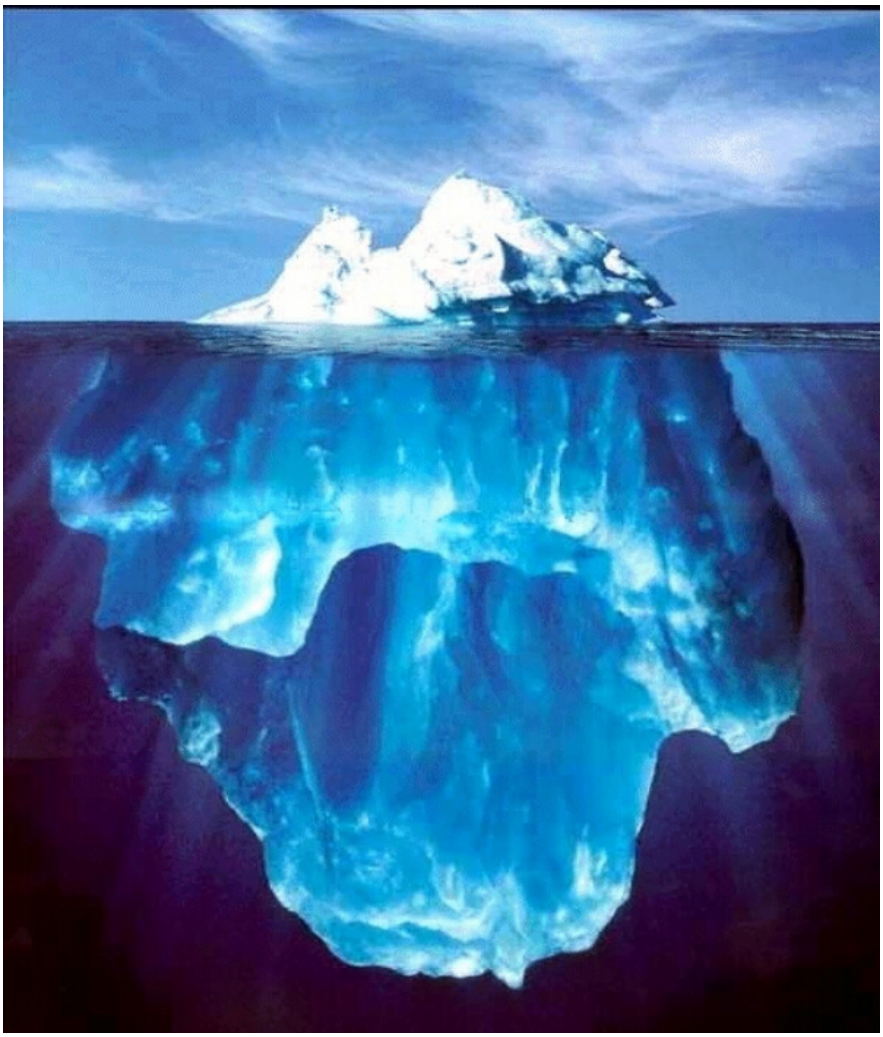
LOOKING BEYOND THE SURFACE:

The Fatal Legacy of Domestic Violence



2007 City of Phoenix
Domestic Violence Fatality Review Team Report

Acknowledgements

The Phoenix Domestic Violence Fatality Review Team (DVFRT) would like to thank City Manager Frank Fairbanks for establishing and providing the Team with the opportunity to thoughtfully consider issues surrounding domestic violence related deaths. We would also like to thank former City of Phoenix Councilwoman Peggy Bilsten for her support of the legislation that authorized the formation of these teams and her support throughout this process. And lastly, we would like to thank all those who volunteered, providing their insight into these deaths, particularly the families of those that lost their loved ones. We hope that their loss may lead to a better understanding of how our system and community responds and what we can do better to address this issue and hopefully avoid such needless tragedy.

Report prepared by DVFRT report subcommittee:

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Process Overview

The stories vary, but the results are equally tragic. Seventy-seven (77) individuals died as a result of domestic violence in the City of Phoenix between 2003 and 2007.[1] During this same period, the Arizona Coalition Against Domestic Violence reported over four hundred and fifty (450) deaths in Arizona related in some manner to domestic violence.[2] While many of these deaths did not fit the statutory definition, domestic violence was a contributing factor.

The Phoenix Domestic Violence Fatality Review Team considered a series of questions at the onset of its review process: How are domestic violence related homicides different from other homicides? What lessons can be learned to better understand these deaths and possibly prevent them? In what ways can the criminal justice system and related agencies respond and intervene with domestic violence? In looking at individual cases, what can be learned about the dynamics that contribute to the death of an innocent person?

The Phoenix Review Team began its work in the spring of 2006, and focused its efforts on understanding the complex dynamics that result in a domestic violence homicide. An initial step for the team was a comprehensive review of a fully-adjudicated 2004 domestic violence homicide case.

Without question, the review of one case has limitations in terms of applicability to all domestic violence related homicides. However, a thoughtful glimpse into the lives of those involved in a domestic violence homicide can paint a picture of how the criminal justice system and the community responded to both the victim and the perpetrator of the homicide. The review provided an opportunity to develop insight into how current policies and practices impacted the myriad of issues surrounding not just this case, but all domestic violence homicides.

Throughout this report, this column will highlight information which will appear in blue while individuals whose deaths should not go unnoticed will appear in black. The Arizona Coalition Against Domestic Violence reported deaths using their definition of "domestic violence related." These deaths occurred in Phoenix during the years 2003 - 2007

source: acadv.org

Seventy seven (77) individuals died as a result of domestic violence in the city of Phoenix between 2003 and 2007

Female, age 51, died August 2004, stabbed and shot by her husband

Executive Summary

Husband and Wife, ages 76 and 72, died April 2005 after being stabbed to death by their grandson

The Phoenix Domestic Violence Fatality Review Team (DVFRT) was created in the spring of 2006. The mission of the team is to examine domestic violence fatalities in order to better understand the dynamics of such deaths and to make system improvement recommendations related to domestic violence cases.[3]

Domestic Violence impacts society on many levels and ranks among the most costly in regards to its social and economic impact. It frequently ranks as one of the top calls for service for law enforcement.[4] Domestic violence homicides are the pinnacle of the overall problem which impacts not only the criminal justice system but also has tragic consequences for families, friends and society.

The DVFRT documented the steps in the review process to help other municipalities and jurisdictions create fatality review teams

Initial work of the oversight committee involved:

- developing a mission
- adopting polices and procedures
- developing rules of operation
- identifying a case selection process
- developing a systematic method for reviewing case information.

The DVFRT documented the steps in the review process to help other municipalities and jurisdictions create fatality review teams. Copies of forms, agreements and bylaws are in the appendices. In addition, the DVFRT analyzed Phoenix's domestic violence statistics for the calendar years from 2003 through 2007 to provide a broader picture of domestic violence-related fatalities in Phoenix than could be drawn from a case review alone.

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The DVFRT adopted a case study methodology as an initial and manageable way of exploring, explaining, and describing the complexities involved in domestic violence cases. It is a method considered appropriate when a holistic, in-depth investigation is needed. Rather than use a larger sample of cases and examine a limited number of variables, this case study gathered as much information as possible on a single case. This helps to describe the events that took place, clarify why actions developed as

they did, explain what opportunities for intervention were taken or missed by the criminal justice system and others. This also illustrates what needs to be done to avoid similar outcomes in the future.

The selected case involved the shooting death of a woman; killed by her former boyfriend and father of their child.

Case review team members examined the following information:

- past criminal history of all parties involved
- prosecution and probation records and related court documents
- medical records of the victim
- police records
- information that is publicly available or provided by the victim's family members, including newspaper articles

Between the ages of fifteen and seventeen, he had been arrested for robbery, rape and attempted murder

Team members also conducted interviews with parents, siblings and children of the victim's family.

The team constructed a timeline of events leading to the murder of the victim to help frame the case. The timeline illustrates where the criminal justice system, the family, the medical community and advocates intervened. The timeline also illustrates other possible points of intervention and potential gaps in the system's response.

Ultimately, this five year relationship culminated with the murder of the victim; a murder that occurred as the child they shared, the child the victim wanted the suspect to parent, watched in horror

Of particular note in this case is that the forty-year-old offender had been involved with the criminal justice system continuously from the time he was fifteen. Between the ages of fifteen and seventeen, he had been arrested for robbery, rape and attempted murder. Prior to the homicide, the offender spent six years in prison for a sexual assault. Ultimately, this five-year relationship culminated with the murder of the victim; a murder that occurred as the child they shared, the child the victim wanted the offender to parent, watched in horror.

Male age 43, died in September 2004, his dismembered body has only partially been recovered. His wife was charged with his murder

What Could We Have Done Differently?

The Team reached four major conclusions. The first addresses the lack of **Offender Accountability**. The case review showed that after being released from prison, the offender was implicated in approximately 12 felonies and nearly as many misdemeanor crimes. If he had been

held more accountable on some of these crimes, he would likely have received significant prison sentences,

thereby removing his opportunity to commit further crimes, including the murder case reviewed here.

There should be an expansion of both the lethality assessment tool used to assist victims and the Phoenix Police Department's "Threats Management" concept currently used for domestic violence cases

The second conclusion calls for a better understanding of **Victimology**. Members of the criminal justice system and domestic violence service providers involved could have worked together to better understand and respond to the victim. The finding of the team is that service providers outside the criminal justice system may have been better skilled and suited to help the victim move to a position of empowerment and strength-based decision making.

The third conclusion speaks to the **Limitations and Gaps** in the criminal justice and other systems' responses. In particular, the DVFRT reviewed the victim's records for an emergency medical room visit. Although the emergency room used a domestic violence screening form, it did not use it fully, suggesting a number of changes for the future.[5] Furthermore, the victim's employer was aware of domestic violence and provided some enhanced security, but again, further lessons on how to effectively respond could be learned. The Law Enforcement response failed to "put the pieces together" and consider this perpetrator a highly lethal offender. Law Enforcement, therefore, did not pursue stronger methods through its Threats Management program. The courts and probation department, although minimally involved, also had many opportunities for intervention. The prosecutors played a critical role, and unfortunately for a variety of reasons, cases against the offender simply did not move forward in the system

Female, age 93, died March 2004 when her 74 year old son beat her to death with a flashlight

Lastly, **Lethality Assessment** was ineffective in this case. There should be an expansion of both the lethality assessment tool used to assist victims and the Phoenix Police Department's "Threats Management" concept currently used for domestic violence cases. These efforts should target offenders for enhanced enforcement who have multiple markers of lethality. Just as repeat offenders are held to stricter penalties and are more accountable for their crimes, domestic violence offenders must be targeted in the same manner when they are repeat offenders.

History

Female, 71 years of age, died January 2006 of blunt force trauma inflicted by her husband using a hammer

Phoenix Domestic Violence Fatality Review Team (DVFRT). On April 18, 2005, Arizona Governor Janet Napolitano signed into law Senate Bill 1071, a law which supported the creation of Domestic Violence Fatality Review Teams.[6]

In May of 2005, Phoenix City Manager Frank Fairbanks officially appointed members to a City of Phoenix Fatality Review Project committee, a body which functions as a subcommittee of the Phoenix Domestic Violence Systems and Process Review (DVSPR) oversight committee. Established in 2002, the Phoenix DVSPR has two goals: to conduct a high level overview of all domestic violence systems processes in place within the City of Phoenix and to identify areas for more detailed analysis in subsequent phases.

The mission of the team is to examine domestic violence fatalities in order to better understand the dynamics of such deaths and to make recommendations for system improvements related to domestic violence

The Phoenix Domestic Violence Fatality Review Team (DVFRT) met for the first time in the spring of 2006. The mission of the team is to examine domestic violence fatalities in order to better understand the dynamics of such deaths and to make recommendations for system improvements related to domestic violence.

Phoenix was the first city in Arizona to form a Domestic Violence Fatality Review Team. The Team relied on the expertise of team members, researched other non-Arizona teams, and consulted the national review team model outlined by National Fatality Review Teams (NFRT).[7]

The Phoenix review team consists of a diverse group of more than twenty (20) people. It represents many disciplines associated with the community response to domestic violence. See Table 1 below for a roster of team members. Team members were responsible for the actual review while Team liaisons applied their expertise regarding certain aspects of the case.

Phoenix was the first city in Arizona to form a Domestic Violence Fatality Review Team

Table 1

(Fatality Review Team Members)

Team Members	Affiliation
Libby Bissa (chair)	Phoenix Family Advocacy Center
Connie Chapman	Phoenix City Prosecutor's Office
Dean Coonrod, M.D.	Maricopa Integrated Health Systems
JoAnn Del-Colle, Director	Phoenix Family Advocacy Center
Heidi Gilbert	Phoenix City Law Department
Katie Hobbs	Sojourner Center, Domestic Violence Shelter
Kristen Hoffmeyer	Maricopa County Attorney's Office
Kim Humphrey, Commander	Phoenix Police Department
Loren Kirkeide	Business Representative/ Employers Against Domestic Violence
Sheri Lauritano	Phoenix City Prosecutor's Office
Kathi Locke	Value Options
Carl Mangold	Batterer's Intervention / Counseling
Chris McBride	Phoenix Public Defender
Greg Miller	Maricopa County Adult Probation Department
Doreen Nicholas	Arizona Coalition Against Domestic Violence
Chris Parks (co-chair)	Police Department Victim Services
Carolyn Passamonte	Maricopa County Superior Court
Benny Pina, Commander	Police Department Violent Crimes Bureau
Kerry Ramella	Fire Department Community Assistance Program
Sandra Renteria, Commander	Phoenix Police Department Family Investigations
Tina Solomon	Phoenix City Prosecutor's Office
Steven Tracy	Faith Community

Team Liaisons	Affiliation
Alex Alvarez	Northern Arizona University
Marcie Colpas	Phoenix Public Information Office
Sandra Hunter	Phoenix City Law Department
Connie Kostelac	Phoenix Police Department Planning & Research
Doug Pilcher	Phoenix Municipal Court

Female, 42 years of age, died July 2004 from blunt force trauma and strangulation inflicted by her estranged husband

Initial work of the oversight committee involved developing a mission statement, adopting polices and procedures, developing rules of operation. The committee also identified a case selection process and a systematic method for reviewing case information. It drafted documents such as confidentiality agreements which the city's legal department reviewed and the committee adopted for use. Initial activities included both the homicide review and the actual review steps and processes.

Female, age 46, died January 2004 after being shot by her boyfriend

As this was the inaugural review, the first case for examination required the development of a case selection process. It was important to select a fully adjudicated case so as not to jeopardize the prosecution of a case.

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The Review Team selected and examined nearly thirty (30) cases with the goal of identifying one case for a "mock review." This review helped determine how the actual review process would work and provided the team with a better understanding of the limits and opportunities available in the actual review. Initially, the team set the goal of completing the first review within one year. Once the Review Team established a review process, it also set a goal to review a minimum of two cases per year. It is important to note that the team's initial timeline was more of a challenge than anticipated due to the amount of time required to secure information from the many systems involved in the case.

The DVFRT documented the steps in the review process to help other municipalities and jurisdictions create fatality review teams. Copies of forms, agreements and bylaws are in the appendices.

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The DVFRT adopted a case study methodology as an initial and manageable way of exploring, explaining, and describing the complexities involved in domestic violence cases. It is a method considered appropriate when a holistic, in-depth investigation is needed. Rather than use a larger sample of cases and examine a limited number of variables, this case study gathered as much information as possible on a single case. This helps to describe the events that took place, clarify why these events developed as they did and explain what opportunities for intervention were taken or missed by the criminal justice system and

others. This also illustrates what needs to be done to avoid similar outcomes in the future.

In addition, to provide a broader picture of domestic violence-related fatality in Phoenix than could be drawn from a case review alone, the DVFRT analyzed domestic violence statistics for the city for the calendar years 2003 through 2007.

The ACADV uses a broader definition of "domestic violence related" by including any homicide with a connection to domestic violence

For the purposes of this review, the Team utilized the definition of domestic violence from Arizona Revised Statute 13-3601, which defines domestic violence relationships as follows:

- *The relationship between the victim and the defendant is one of marriage or former marriage or of persons residing or having resided in the same household.*
- *The victim and the defendant have a child in common.*
- *The victim or the defendant is pregnant by the other party.*
- *The victim is related to the defendant or the defendant's spouse by blood or court order as a parent, grandparent, child, grandchild, brother or sister or by marriage as a parent-in-law, grandparent-in-law, step-parent, step-grandparent, step-child, step-grandchild, brother-in-law or sister-in-law.*

The expertise of the review team members enabled the team to use a diverse pool of data, including statistics, to identify problematic practices and service gap issues in the criminal justice system processes

The City of Phoenix reported twelve (12) domestic violence related homicides in 2006, while the Arizona Coalition Against Domestic Violence (ACADV) reported one hundred and seven (107) throughout Arizona. The ACADV uses a broader definition of "domestic violence related" by including any homicide with a connection to domestic violence. For example, the ACADV's definition would include a new boyfriend of someone killed by their ex-boyfriend even though this situation would not meet the Arizona Revised Statues' criteria.

Husband and wife, both age 51, died August 2004 after the husband stabbed and shot the wife to death, when police responded he pointed a gun at police and was shot and killed by the officer

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Domestic Violence Statistics

(The Past Five Years)

The DVFRT conducted an analysis of all homicides in Phoenix from 2003 to 2007 in order to better understand domestic violence homicide trends. The 2007 data was not fully available at the time of this report.

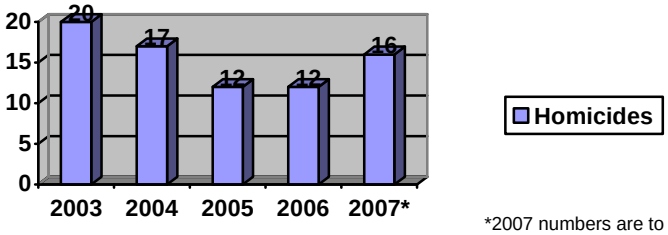
The DVFRT reviewed all homicides in this database with a listed motive of "domestic," as determined by Phoenix Police Department policy, in an effort to critically review domestic violence related homicides

Domestic Violence Related Homicides Demographic Information 2003 - 2007

The Homicide Detail of the Phoenix Police Department maintains an annual, calendar year database that contains all homicides as defined by Arizona Revised Statutes. The DVFRT reviewed all homicides in this database with a listed motive of "domestic," as determined by Phoenix Police Department policy. In an effort to critically review domestic violence related homicides, the DVFRT looked at specific victim and perpetrator characteristics related to race, ethnicity, sex, relationship status, presence and type of weapon(s) and other contributory factors.

Female, age 49, died in April 2005, after her boyfriend shot her and her 16-year-old son who survived his multiple injuries

Phoenix 2003-2007
Domestic Violence Homicides
per Arizona Revised Statute Definition



*2007 numbers are to date and may change

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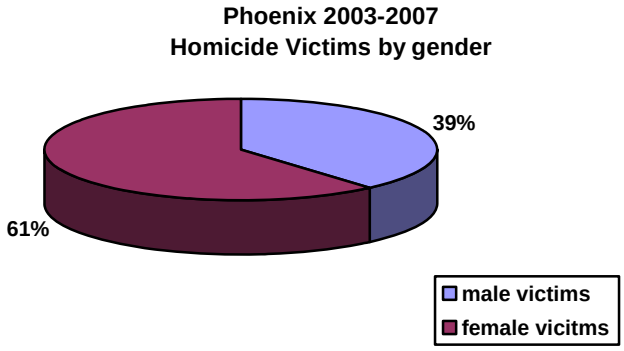
A total of eighty (80) reports were examined; twenty (20) for 2003, seventeen (17) for 2004, eighteen (18) for 2005, fourteen (14) for 2006, and sixteen (16) for 2007. The above chart reflects domestic violence homicides for the calendar years 2003 through 2007. Data is based on

information found in the homicide database or associated departmental reports.

Victim Characteristics

Sixty-one percent (61%) of the homicide victims were females and thirty-nine percent (39%) were male. Between the years 2003 and 2006, the self-reported ethnicity of victims was: forty percent (40%) Hispanic, forty-four percent (44%) Anglo, fourteen percent (14%) African-American, and less than two percent (1.8%) Asian. When examined by year, the statistics fluctuated only slightly, with Hispanics as the largest ethnic group, with the exception of 2004, when Anglo victims accounted for seventy-six percent (76%) and Hispanic victims accounted for eighteen percent (18%).

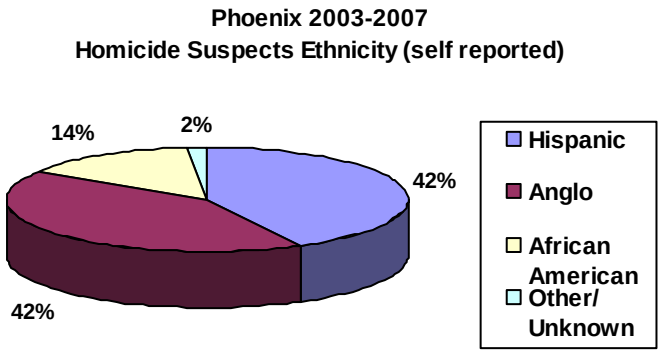
Female, age 2, died March 2005; she weighed only 14 lbs at the time of her death and reportedly had been abused since birth. Her mother was charged with her death



Suspect Characteristics

Between 2003 and 2006, seventy-seven percent (77%) of domestic violence suspects were male. This average had clear variations from year to year with males accounting

Between 2003 and 2006, seventy-seven percent (77%) of domestic violence suspects were male. This average had clear variations from year to year with males accounting for eighty-eight percent (88%) of suspects in 2003 and fifty percent (50%) of suspects in 2006



for eighty-eight percent (88%) of suspects in 2003 and fifty percent (50%) of suspects in 2006. The self-reported breakout of ethnicities for 2003-2006 was consistent with those of victims, with forty percent (40%) of the suspects being Hispanic, forty-four percent (44%) Anglo, fourteen percent (14%) African-American. African American suspect percentages decreased in recent years from a high of thirty-five percent (35%) in 2003 down to less than six percent (5.6%) in 2005 with no incidents reported in 2006.

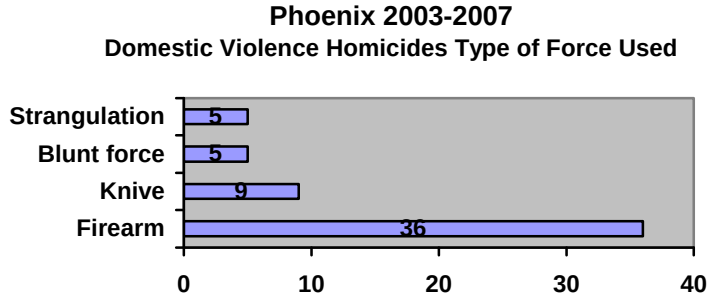
Female, age 33, died February 2007 after her estranged husband came to her place of employment and shot her five times before killing himself

The age of homicide suspects from 2003-2006 was fairly consistent with the age of victims. For example, forty-four percent (44%) of suspects were age thirty-five (35) or younger compared to forty-seven (47%) of victims. Seventy-three percent (73%) of suspects were between eighteen (18) and forty-five (45) years old, while seventy percent (70%) of victims were in this age group. The two largest age groups of suspects, both twenty-eight percent (28%), were eighteen (18) to twenty-five (25) years old and thirty-six (36) to forty-five (45) years old.

…73% of suspects were between eighteen (18) and forty-five (45) years of old, while seventy percent (70%) of victims were in this age group

Weapon Characteristics

From 2003 to 2006, the most commonly used weapon in domestic violence homicides was a firearm, a weapon representing sixty-three percent (63%) of the combined total. The next most common types of force were knives, sixteen percent (16%), and blunt force and strangulation at nine percent (9%).



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Contributing Factors

The following information examines additional factors related to domestic violence homicides. It includes the presence of children, the relationship between the victim

and the suspect, and alcohol and drug use. The statistical homicide database does not capture this information except for relationship status; this information was therefore difficult to locate. Team members obtained this information by reading individual police reports. A further challenge to data collection was that not all contributing factors were included in the narrative of every police report written and reviewed. For the purposes of this review, the Team only considered information about factors contained in a departmental report as contributing factors.

From 2003-2006, the most common relationship between victim and suspect was spouse/significant other which accounted for nearly sixty-five (65%) of the cases

Key contributing factors were:

- From 2003 to 2006, the most common relationship between victim and suspect was spouse/significant other which accounted for nearly sixty-five percent (65%) of the cases.

- In twenty-five percent (25%) of the homicides, children were present at the time of the homicide.

Male, age 41, died March 2006 after he was shot by his estranged wife when she discovered he was in another relationship

- In nineteen percent (19%) of the homicides, the victim or suspect was reportedly under the influence of alcohol and in fourteen percent (14%) of the homicides the victim or suspect was reportedly under the influence of drugs.

The team reviewed police reports to determine the possible involvement of alcohol and drugs. The review team made the determination that alcohol or drug use was present at the time of the homicide if the victim or suspect admitted to consuming alcohol or drugs, a witness saw the victim or suspect consume alcohol or drugs, or alcohol and/or drug use was evident by an odor or through the mannerisms of the victim or suspect.

The team reviewed police reports to determine the possible involvement of alcohol and drugs

Selected Case Overview

The specific case selected for review appeared to cover a number of interesting and important issues. It also included significant background information that would allow for a thorough review, had cooperative family

members, and was fully adjudicated. The case involved the shooting death of a woman; killed by her former boyfriend and father of their child. Case review team members examined the following information for both victim and offender:

- past criminal history of all parties
- prosecution and probation records
- related court documents
- medical records of the victim
- related victim and offender documentation and information that is publicly available or provided by the victim's family members
- interviews with key members of the victim's surviving family including parents, siblings and children.

Between the ages of fifteen and seventeen, he had been arrested for robbery, rape and attempted murder

The team constructed a timeline of events leading to the murder of the victim to help frame the case. To maintain the anonymity of those involved in the case, the timeline of events includes generic, non-identifiable terminology. The timeline illustrates where the criminal justice system, the family, medical community and advocates intervened. The timeline also illustrates other possible points of intervention and potential gaps in the system's response.

Ultimately, this five year relationship culminated with the murder of the victim; a murder that occurred as the child they shared, the child the victim wanted the suspect to parent, watched in horror

Of particular note in this homicide case, was that the forty-year old offender had been continuously involved with the criminal justice system from fifteen years of age. The offender was arrested for robbery, rape, and attempted murder between the ages of fifteen and seventeen. Prior to the homicide, he spent six years in prison for a sexual assault. Subsequent to these crimes, the offender was charged with numerous felonies in three states including forgery, sexual battery, grand larceny, burglary, assault, and other crimes. The most significant fact is that almost every case was never formally charged or resulted in a dismissal or acquittal. The reasons for the dismissal and acquittals varied and included a victim's lack of cooperation with the prosecution.

Male age 43, died in September 2004, his dismembered body has only partially been recovered. His wife was charged with his murder

The most significant fact is that almost every case was never formally charged or resulted in a dismissal or acquittal

According to the victim's family members, the victim and offender began a relationship approximately five years before the homicide. During the course of their relationship, the offender was implicated in a variety of crimes against the victim, including assault, burglary, violations of court orders, and other crimes. In addition,

the offender and victim had a child together but only lived together for a short time.

The victim's attempts to end her relationship with the offender were often compromised by her commitment to encourage the offender to have a relationship with their child

The victim's family reported that the victim chose to maintain a relationship with the offender in an effort to encourage the offender to "be a father to their child." The victim's attempts to end her relationship with the offender were often compromised by her commitment to encourage the offender to have a relationship with their child. Though her efforts were well intentioned, they also gave the offender access to her, he otherwise may not have had. The homicide took place when the offender returned their child after a weekend visit. The offender did not appear to be an active parent, but rather someone with a disjointed, occasional relationship with his child. It could be concluded that the offender used the child for control in the relationship.

The victim had a valid order of protection in place at the time of the homicide

The victim had a valid order of protection in place at the time of the homicide. The order had been served less than one month earlier after repeated harassing phone calls to her workplace. When interviewed, the victim's family felt that orders of protection obtained by the victim were worthless, since the violations of the order usually resulted in no consequences for the offender. This lack of consequences resulted from either a lack of witnesses to the violations or concrete evidence that the violations had occurred. The victim on several occasions filed police reports about order violations but failed to appear for court, resulting in dismissal of the charges.

Furthermore, the team concluded that the victim developed significant distrust in the criminal justice system when initial attempts to hold the perpetrator accountable for criminal conduct (not all directly related to the victim), were unsuccessful

The review revealed numerous identified points of intervention where family members, co-workers, advocates, police and other people spoke with the victim about the dangers of her situation and possible steps she could take to address them. It is also important to note that the victim separated from the offender on several occasions for various periods prior to the homicide.

Furthermore, the team concluded that the victim developed significant distrust in the criminal justice system when initial attempts to hold the perpetrator accountable for criminal conduct (not all directly related to the victim), were unsuccessful.

Issues with the criminal justice process included lack of prosecution, lack of convictions after prosecution, and

occasions when the system missed intervention opportunities. Moreover, the family reported that both they and the victim felt that the criminal justice system failed to hold the offender accountable. Over time, this lack of system-directed accountability for the offender resulted in the victim's choosing not to report criminal activity, testify, appear for court, or cooperate with prosecution, even when the matters before the court involved assaults against her by the offender. The family also believed that the victim had developed an "I can handle the situation and the perpetrator on my own" mentality.

Several factors likely played a significant part in her decision not to end contact. These included her desire to have the offender maintain a parental role with their child and her increasing belief that she, and not the criminal justice system, could best handle the offender's violent behaviors

The victim in several instances obtained an order of protection against the offender. However, she then either failed to follow though with reporting of violations of the order or did not appear in court for the prosecution of violations. Family members and victim advocates repeatedly attempted to help the victim leave the offender; she nevertheless did not end contact with him. The victim remained in contact with the offender even after her teenage child from another relationship moved out of the home due to concerns about the victim not leaving the perpetrator. Approximately three weeks prior to her death, the victim again moved and attempted to sever contact with the suspect. However, the suspect either followed the victim to find her address or she contacted him by phone and contact was re-established. Several factors likely played a significant part in her decision not to end contact. These included her desire to have the offender maintain a parental role with their child and her increasing belief that she, and not the criminal justice system, could best handle the offender's violent behaviors.

Male, age 52, died July, 2004 after his brother beat him to death with a golf club for allegedly "not helping with the cleaning"

Timelines

The following two pages contain timelines of events. The first outlines the offender's journey through the criminal justice system; a separate timeline shows the events leading to the fatality. The information shown is somewhat generic to assist in maintaining the anonymity of the case.

Time Line Graphically Displayed

Time Line Graphically Displayed page 2

Factual Observations - Case Review

1) The offender had an extensive criminal record beginning at age fifteen (15). Between the ages of fifteen (15) and seventeen (17), he was arrested in a series of serious crimes including robbery, rape and attempted murder. Throughout his life, the offender was arrested for numerous felony crimes yet he was rarely held accountable for these crimes. The reasons range from lack of evidence and victim's recanting to unknown issues that led to dismissals of cases.

It is critical to note that the offender's long history of not being held accountable for crimes may have resulted in the offender seeing himself as "not guilty" and/or "not responsible" for these crimes…

2) It is believed that the victim was aware of the offender's criminal history and propensity for violence. The depth of the victim's knowledge was likely dependent on how much the offender chose to share. It is critical to note that the offender's long history of not being held accountable for crimes may have resulted in his seeing himself as "not guilty" and/or "not responsible" for these crimes. He likely shared this perspective with the victim when he did speak of his criminal history. In addition to committing numerous crimes against the victim, including aggravated assault, the offender made many direct and indirect threats to the victim indicating his intention to kill her. Also, several witnesses reported that the offender openly made specific threats to kill the victim.

The criminal justice system, through advocates, police officers, prosecutors and the court, all attempted to intervene and provide services to the victim

3) The criminal justice system, through advocates, police officers, prosecutors and the court, all attempted to intervene and provide services to the victim. The DVFRT documented that the victim was aware of services available to her. The victim had even discussed these services with family and friends. It does appear, however, that the victim's first documented contact with an advocate was not until about three years after the abuse started.

Husband and wife, ages 36 and 32, died October 2004 after the husband shot his wife and then killed himself in front of their 15-year-old daughter who fled the scene with her siblings, ages 10, 8 and 8 months

Additionally, though the victim did act on some information, such as securing orders of protection, the victim just as often did not follow through on securing support services which may have helped her remain safe.

4) The victim's family and friends also attempted to intervene and warn the victim to end contact with the offender. The victim's family, as shown by the choice of the victim's teenage child to leave the home because of personal safety concerns, recognized the danger of the situation.

Additionally, though the victim did act on some information, such as securing Orders of Protection, the victim just as often did not follow through on securing support services which may have helped her remain safe

What Could We Have Done Differently?

Male, age 76, died February 2004 after being beaten to death with a shovel by his son

Conclusion #1: Offender Accountability

Prior to committing this homicide, the offender had a lengthy criminal history and had already spent at least six years in prison in another state. He had also spent time in jail for crimes in three states. The review of this case revealed that after being released from prison, the offender was implicated in approximately twelve felonies and nearly as many misdemeanor crimes. If the offender had been convicted on even a few of these crimes, he would have received additional prison sentences and perhaps not been able to commit more crimes against this victim. In addition, incarceration could have provided the victim with time to secure the resources she needed to safely end the relationship.

In addition, incarceration could have provided the victim with time to secure the resources she needed to safely end the relationship

Conclusion #2: Limitations & Gaps Specific System Responses

Advocacy: It appears that a victim advocate did not work with the victim until three years after the abuse began. Having an advocate from the onset of the first case could have helped the victim obtain critical knowledge about the workings of the criminal justice system as well as concrete

Having an advocate from the onset of the first case could have helped the victim obtain critical knowledge about how the criminal justice system works as well as concrete resources and emotional support

resources and emotional support. For example, an advocate could have educated the victim about how to collect corroborating evidence so the violations of orders of protection could have been successfully prosecuted. Such documentation could have resulted in his violation of the third order of protection being sent to the county court system for felony prosecution as Aggravated Domestic Violence. This could have resulted in jail time that would have given the victim enough time to stabilize her life.

Courts also need to understand the specifics and dynamics of domestic violence

An advocate could have provided resources to relocate, a change of locks for her residence, emotional support, as well as educational and financial resources. Furthermore, an advocate could have worked with the victim to alleviate her fears, thus increasing the likelihood that she would have remained engaged in the criminal justice process.

Husband, wife and daughter, ages 43, 38 and 4, died May 2004 when the husband shot and killed his wife and daughter before killing himself

Courts: As noted above in conclusion #1, "offender accountability" was a critical issue in this case review. As a general rule, courts need to thoroughly review an offender's criminal history and respond appropriately. Courts also need to understand the specifics and dynamics of domestic violence. The victim's distrust of the system in part reflected her frustration with what she perceived as the court's mishandling of the offender's cases. The failure to reach out to the victim and follow through with additional assistance was, as already noted, likely one of the contributing factors to this homicide. Of course, the courts can only get involved if the cases are brought before them. In the reviewed case, many of the crimes or charges surrounding the offender and the victim were dropped or adjudicated prior to reaching the court.

Employers with a plan on how to deal with domestic violence could provide invaluable support and / or referral to appropriate resources

Employers: Employers can also play a role in the intervention and prevention of Domestic Violence. The offender in this case had direct confrontations with the victim in her place of employment. Some individuals at her work tried to provide additional security. The employer appeared to have knowledge of some of the problems facing the victim but it appears they did not intervene more significantly. Employers with a plan on how to deal with domestic violence can provide invaluable support and / or referral to appropriate resources. For further information on how employers can get involved, contact the Arizona Foundation for Women for information on the "Employers Against Domestic Violence" (EADV) Program.[8]

Law Enforcement: Law enforcement played a critical role in this case, intervening in the lives of the victim and offender on dozens of occasions. Again, officers, if armed with enough information on the history of this volatile relationship, could have forged a different response. Educating the victim on how to document orders of protection violations, providing additional support to the victim, and building stronger cases all may have led to different outcomes. For example, based on the information reviewed, felony cases of stalking, aggravated harassment, or prohibited possession of firearms could have been established with more investigative follow-up and background research. Furthermore, if the offender had been identified as a repeat offender in the law enforcement investigation, new cases could have resulted in stiffer penalties.

… better-educated officers armed with enough information on the history of this volatile relationship could have forged a different response

Female and her ex-boyfriend, ages 26 and 41, died January 2004 when he shot her numerous times and then killed himself after she obtained an Order of Protection against him

Medical: The DVFRT reviewed the victim's medical records in connection with a medical emergency room visit. Most local hospitals over the past several years have voluntarily adopted a domestic violence screening tool. The hospital did use a domestic violence screening form. While the hospital staff did use the form, it did not use it to its fullest capability. For example, the victim reported injuries, but the staff did not include the injuries on the body map. The form documented multiple markers for lethality, including fear, escalating violence, threats of homicide and suicide, and substance abuse. Despite this, the records do not document any safety planning or referrals to domestic violence hotlines or social workers. The medical documentation only notes a law enforcement report.

Medical records should report what was stated by a victim without any judgment or opinion about the statements made

The physician's report frequently used the word "alleges" and did not specify more details about the perpetrator. It is recommended that "alleges" not be used in medical records and that a more neutral word, "states," should be used. Another medical record reported that the "ex-boyfriend" was cited as a reason for not pursuing prosecution: This further underlines the need to use specificity regarding the perpetrator. Medical records should report a victim's statements without any judgment or opinion about the statements made.

Probation: Probation could have played an important role in this case had the offender been convicted of some

or all of his alleged crimes. This would have allowed the Probation Department to maintain supervision and track the offender's actions and probation violations. It could also provide additional information and resources to the victim. The review identified the need for more domestic violence specific education and stronger accountability for the offender. Supervised misdemeanor probation sentences would lead to greater scrutiny, oversight of offenders, and provide opportunities for intervention with victims.

Supervised misdemeanor probation sentences would lead to greater scrutiny, oversight of offenders, and provide opportunities for intervention with victims

Prosecution: Prosecution interacted with the victim and the offender on numerous occasions. These included violations of protective orders, domestic violence related criminal charges, and other charges against the offender. The victim would have benefited if either a victim advocate and/or prosecutor had provided her more education regarding what is needed for the successful prosecution of an order of protection or domestic violence cases. As noted throughout this review, identifying offender patterns such as stalking, aggravated harassment, or repeated violations, would have provided a stronger framework for more aggressive prosecution.

Male age 56, died December 2004, when he was stabbed multiple times with scissors by his male partner who left him to die in his home

Conclusion #3: Victimology

Members of the criminal justice system and domestic violence services providers could have utilized a comprehensive team approach to better understand and respond to the victim. Working as a team could have increased the effectiveness of the responses to both the defendant's repeated criminal behaviors and the victim's critical need for information, support and advocacy.

Of particular importance was the challenge of understanding this victim's mindset and choices without judgment. This victim experienced a lack of responsiveness from the criminal justice system and thus decided to handle the violence and the offender in a manner that appears to work but ultimately put her at mortal risk.

Of particular importance was the challenge of understanding this victim's mindset and choices without judgment

One notable issue for this victim was her desire to maintain contact with the offender in order to promote a relationship between the offender and their child. This played a key role in the homicide. Having a protocol for

safe visitation exchange in domestic violence situations may have saved this victim's life.

Lastly, better communication among the victim, the victim's family, law enforcement and other parties who intervened could have provided the victim with the support and assistance she needed to make an empowered decision about the safety needs of herself and her children. The reality is that service providers outside the criminal justice system may have been better skilled and suited to help this victim move to a position of empowerment and strength-based decision making.

…better communication among the victim, the victim's family, law enforcement and other parties who intervened could have provided the victim with the support and assistance she needed to make an empowered decision about the safety needs of herself and her children

Conclusion #4: Lethality Assessment

An expansion of both the lethality assessment tools used to assist victims and the current Phoenix Police Department "Threats Management" resources provided to domestic violence victims is needed. The system must be able to focus efforts and resources on offenders who present a high degree of lethality. Just as repeat offenders are held to stricter penalties and are more accountable for their crimes, though apparently not in this offender's case, domestic violence offenders must be targeted in the same manner when they are repeat offenders. Increased use of threat management teams that focus on high lethality risk situations will result in harsher penalties and stronger sentences. In this as in other cases, offenders cannot commit crimes of domestic violence when they are incarcerated.

Female and her ex-husband, ages 26 and 24, died December 2005 after her ex-husband shot her and her boyfriend multiple times before killing himself. The ex-boyfriend survived as well as her 2-year-old child who was struck by a stray bullet

Next Steps – Recommendations

Develop a multi-department/agency Phoenix domestic violence coordination team to review and staff serious and/or repeat offender cases below the threshold for assignment to the Police Threats Management Team

Offender Accountability

- Increase communication among misdemeanor and felony prosecution units to ensure that domestic violence perpetrators are held fully accountable for all crimes committed. This must include both violent and non-violent crimes. This includes more prosecution of aggravated domestic violence charges and not allowing for the dropping of the Domestic Violence designation in plea bargains.[9]

- Develop a multi-department/agency Phoenix domestic violence coordination team to review and staff serious and/or repeat offender cases below the threshold for assignment to the Police Threats Management Team. Team members should include law enforcement, city and county prosecution staff, city and county victim advocates, probation staff and others as needed and appropriate for a specific domestic violence case.

Male, age 27, died November, 2004 when his girlfriend's ex-boyfriend stabbed him to death in her apartment

- Develop "best practices" protocols for the Threat Management Team. Protocols should include how cases are identified and managed by the team, as well as how to document the team's actions and efforts.

Limitations & Gaps / Specific System Responses

- Increase the use of forensic medical exams in domestic violence cases. This will require ongoing training for medical staff regarding documentation of injuries of domestic violence victims who are seen in emergency rooms and urgent care centers. Forensic medical exams will strengthen the already established treatment and documentation practices related to objective documentation of victim injuries through notes, records, drawings and photographs.

Develop cross system communication abilities among prosecutors, advocates, police and probation units

- Develop cross system communication abilities among prosecutors, advocates, police and probation units. Currently, victim information is

often maintained in systems that do not allow for information sharing that can keep victims informed of an offender's ongoing criminal justice system involvement.

- Additional advocates need to be hired and a system established so that domestic violence victims receive information from a supportive person at the scene within twenty-four (24) to forty-eight (48) hours after a domestic violence crime. Currently, that is not being done on all cases. According to the Morrison Institute Report, "System Alert, Arizona's Criminal Justice Response to Domestic Violence," victims feel they get more help from advocates than anyone. They noted that "victims felt comfortable dealing with advocates and saw them as both meeting their needs and helping produce a better result in their case."[10]

Additional advocates need to be hired and a system established so that domestic violence victims receive information from a supportive person at the scene within twenty-four (24) to forty-eight (48) hours after a domestic violence crime

Victimology

- Increase the knowledge and skills of all members of the criminal justice system regarding the dynamics of victimology. Examples include but are not limited to understanding a victim's decision to stay, making plans regarding personal safety, working with the criminal justice system, disclosing abuse to family and friends and choosing to disengage from formal systems in an effort to self-manage the perpetrator's abusive behaviors.

Increase the knowledge and skills of all members of the criminal justice system regarding the dynamics of victimology

Lethality Assessment

- Develop improved processes for assessing lethality for domestic violence victims. These processes should include but are not limited; identifying improved lethality assessment tools, strengthening case management processes and enhancing communication among criminal justice team members. This addresses lethality concerns in a timely, concrete manner.

Female, age 30, died March, 2007 when her husband came to Phoenix allegedly after she asked for a divorce. He murdered her before fleeing to another country

APPENDICES

Appendix I Forms – Family Member Confidentiality Agreement

CITY OF PHOENIX
DOMESTIC VIOLENCE FATALITY REVIEW TEAM
Family Member or Relative Confidentiality Agreement

The purpose of the City of Phoenix Domestic Violence Fatality Review Team (DVFRT) is to conduct a complete retrospective analysis of family or intimate partner violence death incidents. The goal of the DVFRT is to address systemic issues and not to place blame.

I, the undersigned, as a family member or relative of the listed victim, _____, understand my role is to assist the DVFRT by providing information which helps the DVFRT to perform its review.

I understand that the final published report will be a public record and that it will contain no personal identifying information. I understand the DVFRT may not share all of its information with me nor will it provide to me all of the confidential information gathered during the review process. I understand that I will have no editorial authority over the final published report. Upon written request to the Chair of the DVFRT, one copy of the final published report will be made available for all involved family members and relatives to review.

I swear or affirm that I shall not divulge any information, records, discussions and opinions disclosed during any closed meeting to review a specific death. Such information, records, discussions and opinions shall remain confidential and shall not be used for reasons other than those required under § 41-198 of the *Arizona Revised Statutes* or by court order.

_____
Print Name

_____ _____
Signature *Date*

Appendix 1 Forms – Interagency Confidentiality And Cooperation Agreement

CITY OF PHOENIX
DOMESTIC VIOLENCE FATALITY REVIEW TEAM
Interagency Confidentiality And Cooperation Agreement

To be signed by a representative of each agency agreeing to participate in the City of Phoenix Domestic Violence Fatality Review Team

Organization: _____

Represented by: _____

This cooperative agreement is made this _____ day of _____, 2006 between _____ and all agencies and individuals who serve on the City of Phoenix Domestic Violence Fatality Review Team (DVFRT):

On behalf of _____, I indicate our support of the objectives of the Phoenix DVFRT, established pursuant to A.R.S. § 41-198.

Through the process of conducting a formal review of selected fatalities in which family violence or intimate partner violence is considered a significant factor; the
DVFRT will examine incidents of domestic violence related fatalities to better understand the dynamics of these fatalities; and may:

1. Identify and describe trends and patterns in family or intimate partner violence related fatalities by documenting trends and patterns in periodic reports which present the aggregated findings of the domestic violence fatality reviews conducted in the City of Phoenix.

2. Work to increase safety for victims and accountability for perpetrators of family or intimate partner violence by:
    a. Promoting cooperation and communication among agencies investigating and intervening in family or intimate partner violence.
    b. Identifying gaps in services and accountability structures and formulating recommendations for policies, services and resources to fill those gaps.

3. Formulate recommendations for collaboration on family or intimate partner violence investigation, intervention and prevention.

_____ agrees that membership of the DVFRT should be comprised of (but not limited to) the following: a representative from a county or municipal law enforcement agency; a representative of a county or municipal court; a representative of a county or municipal prosecutor's office; a

Appendix 1 Forms – Interagency Confidentiality And Cooperation Agreement (cont.)

representative of a local domestic violence prevention program; a victim of domestic violence; a representative of a county or state public health agency; a representative of the Office of the County Medical Examiner; if Child Protective Services received a report on any person residing with the victim before the fatality, a representative of Child Protective Services who serves the area covered by the review team for the duration of the review of that fatality; and a representative of a statewide domestic violence coalition.
This participating organization will provide an ongoing primary representative and an alternate representative on a regular basis as the member of the Review Team and provide necessary information to support the DVFRT's operations.

All information and records acquired by a review team are confidential and are not subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding or disciplinary action. Information that is otherwise available from other sources is not immune from subpoena, discovery or introduction into evidence through those sources solely because they were presented to or reviewed by a review team.

I understand and acknowledge that the unauthorized disclosure of confidential records, reports, investigation materials and information may result in criminal and civil liability.

Because the review process may involve case specific sharing of information, and confidentiality is inherent in many of the involved reports, each member of the DVFRT will take clear measures to understand the limits of what they may reveal in their capacity as an agency representative. All members will sign a confidentiality agreement that prohibits any unauthorized dissemination of information related to the review process. No material may be used for reasons other than which was intended.

_____ agrees that no one associated with this agency will represent the views of the DVFRT to the media.

In my capacity as its authoritative representative, I commit _____'s participation, support and assistance to the DVFRT.

This agreement will be in effect on the date below. I can request a revision or review of this agreement within thirty (30) days of written notice. Notice of revision or termination of this agreement will be sent to all members of the DVFRT.

Signature: _____ _____

Agency Representative City of Phoenix DVFRT

Title: _____

Date: _____

Appendix 1 Forms – Individual Confidentiality Agreement

CITY OF PHOENIX
DOMESTIC VIOLENCE FATALITY REVIEW TEAM
Individual Confidentiality Agreement

The purpose of the City of Phoenix Domestic Violence Fatality Review Team (DVFRT) is to conduct a complete retrospective analysis of family or intimate partner violence death incidents. I, the undersigned, as a representative of _____ swear or affirm that I shall not divulge any information, records, discussions and opinions disclosed during any closed meeting to review a specific death. Such information, records, discussions and opinions shall remain confidential and shall not be used for reasons other than those required under § 41-198 of the *Arizona Revised Statutes or by court order*. **Violation of this agreement is a Class 2 Misdemeanor.**

_____
Print Name

_____ _____
Signature *Date*

Appendix 1 Forms – Authorization to Release Medical Records

CITY OF PHOENIX
DOMESTIC VIOLENCE FATALITY REVIEW TEAM

AUTHORIZATION TO RELEASE MEDICAL RECORDS

TO: DATE:

I have agreed to allow the City of Phoenix Domestic Violence Fatality Review Team (DVFRT) to conduct a retrospective analysis of the domestic violence homicide of my son/daughter/family relationship, Victim's Name .

As part of this process, I hereby authorize you to release copies of medical records and health information for the following individuals:

_____ (deceased)	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

Please forward copies of the medical records and health information to:

Address
ATTN: Chairperson

The information may be spoken, written, electronic, or in any other form and is solely for the purpose of the DVFRT's assessment. I understand that the information provided may be incorporated into the DVFRT's assessment, but any personal identifying information will be omitted. I understand that upon completion of the DVFRT's assessment, the information provided, including any notes, will be destroyed.

I avow that I have the legal authority to make such an authorization on behalf of the individuals designated above. I understand that I may also be asked to provide documentation to support this

Appendix 1 Forms – Authorization to Release Medical Records (cont.)

avowal and/or sign an additional authorization form provided by you prior to the release of any records or other information.

I understand that a photocopy of this authorization is considered acceptable in lieu of an original.

I understand that this authorization is voluntary and that I have the right to revoke this authorization at any time by notifying (in writing) the DVFRT located at:

Address
ATTN: Chairperson

I understand that such a revocation is only effective after it is received and logged by the Chairperson of the DVFRT. I understand that any use or disclosure made prior to the revocation of this Authorization Form will not be affected by the revocation.

I understand that this authorization will expire on _____ , 20___ , or upon the completion of the DVFRT's assessment, whichever occurs first.

_____ _____
Signature Date

Appendix 1 Forms – Team Agreement to Maintain Confidentiality

CITY OF PHOENIX
DOMESTIC VIOLENCE FATALITY REVIEW TEAM
Agreement to Maintain Confidentiality

To be signed by each person in attendance at each Domestic Violence Fatality Review Team meeting

By signing this form, I do hereby acknowledge and agree to the following:

I agree to serve as a member of the Phoenix Domestic Violence Fatality Review Team (DVFRT). I acknowledge that the effectiveness of the fatality review process is dependent on the quality of trust and honesty team members bring to it. Thus, I agree that I will not use any material or information obtained during the DVFRT meeting for any reason other than that which it was intended.

I further agree to safeguard the records, reports, investigation material, and information I receive from unauthorized disclosure. I will not take any case identifying material from a meeting. Thus, I will not make copies or otherwise document/record material made available in these reviews, including electronically. I will return all material shared by others at the end of each meeting. Pursuant to A.R.S. § 41-198(I), the DVFRT will return all information and records concerning the victim and the family to the agency that provided the information or, if directed by that agency, it shall destroy that information.

I understand and acknowledge that the unauthorized disclosure of confidential records, reports, investigation materials and information may result in civil or criminal liability and exclusion from the DVFRT. **Violation of the confidentiality provision of A.R.S. § 41-198 is a Class 2 Misdemeanor.**

I agree to refrain from representing the views of the DVFRT to the media.

	Printed Name	Signature	Date
1			
2			
3			
4			
5			
6			
7			
8			
….			

Appendix II Review Team Members and Liaisons Profiles

Alex Alvarez – Dr. Alex Alvarez earned his Ph.D. in Sociology from the University of New Hampshire in 1991 and is a Professor in the Department of Criminal Justice at Northern Arizona University. From 2001 until 2003 he was the founding Director of the Martin-Springer Institute for Teaching the Holocaust, Tolerance, and Humanitarian Values. His main areas of study are in the areas of collective and interpersonal violence, including homicide and genocide.

Libby Bissa – Ms. Bissa is the Operations Manager for the City of Phoenix Family Advocacy Center and the Chair of the Phoenix Domestic Violence Fatality Review Team. Ms. Bissa holds a Bachelors degree in Business Administration and 22 years experience in municipal government, including emergency services and operations management.

Connie Chapman – Ms. Chapman is the Victim Services Administrator of the City of Phoenix Prosecutor's Office Victim Services Program. The Victim Services Unit provides services to victims of misdemeanor crimes that occur in the City of Phoenix. Ms. Chapman is the chair of the Arizona Victim Assistance Academy that provides statewide training to advocates.

Marcie Colpas – Ms. Colpas is a public information officer and has been with the city of Phoenix for 22 years. Ms. Colpas has also worked for the Arizona Department of Commerce as a public information officer. Ms. Colpas is a member of 3CMA, a professional organization for state and county public information professionals.

Dean Coonrod, MD-MPH – Dr. Coonrod is the Chair of Obstetrics and Gynecology at Maricopa Integrated Health System and MedPro, is published in the area of violence against women and has launched a model hospital-based DV advocacy program. Dr. Coonrod's memberships include Sojourner Center Board of Directors, MAG DV Council and the Governor's Commission to Prevent Violence Against Women.

JoAnn Del-Colle – Ms. Del-Colle is the Director of the Phoenix Family Advocacy Center. Ms. Del-Colle has over 17 years of experience working in the field of domestic and sexual violence. Ms. Del-Colle is a licensed clinical social worker and received her BA in Family Studies and her Masters in Social Work from ASU.

Heidi Gilbert – Ms. Gilbert is an attorney in the Civil Division of the City of Phoenix City Attorney's Office.

Katie Hobbs – Ms. Hobbs has been a social worker since 1992. She has been with Sojourner Center since 2000. As Director of Government Relations, Ms. Hobbs is involved in several community-wide domestic violence coordination efforts and works to engage domestic violence survivors in the legislative process and social action.

Kristen Hoffmeyer – Ms. Hoffmeyer is a Deputy County Attorney in the Homicide Bureau of the Maricopa County Attorney's Office. Ms. Hoffmeyer has been a prosecutor for 13 years and currently handles a caseload which includes domestic violence murder prosecutions.

Kim Humphrey – Commander Humphrey is currently the commander of the Phoenix Police Professional Standards Bureau and has been with the Department for 25 years. Kim has overseen the domestic violence unit and is involved extensively in the issue including; vice-chair of the MAG Regional Domestic Violence council, member of the Men's Anti-violence Network, current president of the Board at Sojourner Center Shelter and on the Board of Homeward Bound a transitional housing non-profit.

Sandra Hunter – Ms. Hunter is currently an Assistant City Attorney for the City of Phoenix, representing the Police Department. Ms. Hunter has worked for the City since the 1990s with previous positions as a prosecutor, a training attorney, and an employment and discrimination specialist. As a prosecutor, Ms. Hunter specialized in the prosecution of domestic violence offenders.

Loren Kirkeide – Mr. Kirkeide works in the Planning Department at SRP. He also serves on the Board of Sojourner Center (a domestic violence shelter), the Employers Against Domestic Violence (EADV) business organization and the Governor's Commission On Violence Against Women.

Constance (Connie) Kostelac – Ms. Kostelac is a Police Research Supervisor for the Phoenix Police Department's Crime Analysis and Research Unit (CARU). Ms. Kostelac has been with the Phoenix Police Department since 1999. Ms. Kostelac holds an MS in Criminology and Criminal Justice and is a doctoral candidate in Justice and Social Inquiry at Arizona State University.

Sheri Lauritano – Ms. Lauritano served as a prosecutor for the City of Phoenix. Ms. Lauritano also served as the chair of the City of Phoenix Domestic Violence Task Force.

Kathi Locke – Ms. Locke holds a Master of Counseling degree from ASU and is a Licensed Professional Counselor. Ms. Locke has been employed in diverse behavioral health settings in Arizona since 1991. Ms. Locke is currently Site Administrator and Clinical Director in an outpatient psychiatric clinic for Magellan Health Services.

Carl W Mangold – Mr. Mangold, a licensed clinical social worker, began working as a pastor in the field of domestic abuse in the 1970s. Mr. Mangold has served on a shelter board, counseled numerous victims, treated 3,500 mandated male offenders, served on the Arizona Coalition Against Domestic Violence board and is currently the Director of Program Services at Chrysalis.

Chris McBride – Mr. McBride is the Assistant Director for the City of Phoenix's Public Defender's Office.

Greg Miller – Mr. Miller, a probation supervisor with the Maricopa County Adult Probation Department manages the Domestic Violence Unit and has been with the department for over eighteen years. Additionally, Mr. Miller serves on the City of Glendale's Domestic Violence Task Force and is an adjunct faculty member with the University of Phoenix.

Doreen Nicholas – Ms. Nicholas is the Training Coordinator for the North Carolina Coalition Against Domestic Violence. Prior to her current position Ms. Nicholas served as the Training Coordinator for the Arizona Coalition Against Domestic Violence for 12 years. Ms. Nicholas has over 30 years of experience in the fields of domestic violence and human services.

Chris Parks – Ms. Parks, the Vice Chair of the DVFRT has worked in the Victim Services field for over 17 years. Ms. Parks has served as the Victim Services Coordinator for the Phoenix Police Department since 1998. Ms. Parks has a Bachelor of Arts Degree in Psychology and a Master's Degree in Counseling.

Carolyn Passamonte – Ms. Passamonte serves as a Commissioner for the Maricopa County Superior Court.

Doug Pilcher – Mr. Pilcher is the City of Phoenix Criminal Court Administrator and has over 20 years of experience in community corrections. Mr. Pilcher holds a Bachelors degree in Justice Studies, a Master of Education degree and serves on Supreme Court committees addressing domestic violence and victim issues.

Benny Piña – Commander Piña was recently promoted and serves as the Phoenix Police Department Duty Commander. Commander Pina has also served as the Violent Crime Bureau Homicide Unit Lieutenant and in that role provided oversight to all homicide and death investigations for the department. Commander Pina has been with the Phoenix Police Department for eighteen years.

Kerry Ramella – Ms. Ramella is a Licensed Professional Counselor and has managed the Phoenix Fire Department Crisis Response (CR) Program for six years. The CR units provide on scene crisis intervention and victim assistance 24/7. Ms Ramella also oversees the coordination of the MAG Regional Crisis Intervention Training Academy.

Commander Sandra Renteria – Commander Renteria has been in law enforcement for over 19 years. Commander Renteria has served as the co-chair of the City of Phoenix Domestic Violence Task Force and has been a member of the MAG Domestic Violence Task Force. Commander Renteria served as the Lieutenant for the Domestic Violence Unit in the Family Investigations Bureau.

Tina Solomon – Ms. Solomon is an Assistant City Prosecutor with the City of Phoenix. Ms. Solomon has been a prosecutor for over eight years and is currently assigned to

the Domestic Violence Unit. Ms. Solomon prosecutes misdemeanor DV cases and works with advocates, victims and witnesses on a daily basis.

Steve Tracy, M.Div, Th.M., Ph.D. – Dr. Tracy is a founding board member of Mending the Soul Ministries, a faith based abuse organization. Dr. Tracy is also a Professor of Theology and Ethics at Phoenix Seminary. Dr. Tracy received his Ph.D. in religious ethics from the University of Sheffield (England) and is the author of two books and numerous articles on gender, sexuality, and abuse.

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[1] Phoenix Police Department Crime Analysis Response Unit, Domestic Violence Related Homicides Demographic Information 2003-2007 Report

[2] Arizona Coalition Against Domestic Violence 2003-2007 AZ domestic Violence Related Deaths Reports, www.azcadv.org/

[3] Domestic Violence Fatality Review Team Fact Sheet, City of Phoenix

[4] System Alert Arizona Criminal Justice Response to Domestic Violence, Report by the Morrison Institute for Public Policy, Arizona State University, October 2007, Executive Summary pg. i, available at www.morrisoninstitute.org

[5] For a sample Medical Screen Form. Contact Maricopa Integrated Health System, Maricopa County Arizona

[6] Senate Bill 1071, Amending Article 41, Chapter 1, Article 5, Arizona Revised Statues, by adding section 41-198;relating to domestic violence fatality review teams, forty seventh legislature first regular session, 2005

[7] Web address for the National Fatality Review Team (NFRT) and related resources, http://ican-ncfr.org/hmDomesticViolenceReview.asp

[8] Arizona Foundation for Women, "Employees Against Domestic Violence Program (EADV) 2828 N. Central Avenue, Suite 1200, Phoenix, AZ 85004 Phone: 602.532.2800, http://www.azfoundationforwomen.org

[9] System Alert Arizona Criminal Justice Response to Domestic Violence, Report by the Morrison Institute for Public Policy, Arizona State University, October 2007, Recommendations "Attending to Victim Needs" pg. 77, available at www.morrisoninstitute.org

[10] System Alert Arizona Criminal Justice Response to Domestic Violence, Report by the Morrison Institute for Public Policy, Arizona State University, October 2007, "Victims five thanks for advocates work" pg. 41, available at www.morrisoninstitute.org