Murder in Oklahoma

Oklahoma Domestic Violence Fatality Review Board

Annual Report
July 2001-September 2002

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Acknowledgements

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Oklahoma State Bureau of Investigation
Office of the Chief Medical Examiner
Oklahoma Department of Mental Health & Substance Abuse Services
Oklahoma Department of Human Services

County Sheriffs

Adair County Sheriff's Office
Bryan County Sheriff's Office
Caddo County Sheriff's Office
Canadian County Sheriff's Office
Carter County Sheriff's Office
Cherokee County Sheriff's Office
Cotton County Sheriff's Office
Craig County Sheriff's Office
Creek County Sheriff's Office
Delaware County Sheriff's Office
Garvin County Sheriff's Office
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Jackson County Sheriff's Office
Kay County Sheriff's Office
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Stephens County Sheriff's Office
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Anadarko Police Department
Apache Police Department
Ardmore Police Department
Bartlesville Police Department
Broken Arrow Police Department
Broken Bow Police Department
Chandler Police Department
Coweta Police Department
Cushing Police Department
Del City Police Department
Dewey Police Department
Duncan Police Department
Durant Police Department
Edmond Police Department
El Reno Police Department
Enid Police Department
Frederick Police Department
Glenpool Police Department
Grove Police Department
Guymon Police Department
Harrah Police Department
Heavener Police Department
Henryetta Police Department
Hobart Police Department
Jenks Police Department
Lawton Police Department
Mangum Police Department
Marlow Police Department
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Midwest City Police Department
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Nicoma Park Police Department
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Oklahoma City Police Department
Owasso Police Department
Perry Police Department
Ponca City Police Department
Poteau Police Department
Pryor Police Department
Purcell Police Department
Sallisaw Police Department
Shawnee Police Department
Skiatook Police Department
Stillwater Police Department
Stilwell Police Department
Sulpher Police Department
Tecumseh Police Department
Tonkawa Police Department
Tulsa Police Department
Valley Brook Police Department
Wakita Police Department
Warr Acres Police Department
Weatherford Police Department
Wilburton Police Department
Yukon Police Department

District Attorneys

Donald E. Wood	District 1	John David Luton	District 15
Richard Dugger	District 2	Rob Wallace	District 16
John Wampler	District 3	Virginia Sanders	District 17
Cathy Stocker	District 4	Kalyn Free	District 18
Robert Shulte	District 5	James Thornley	District 19
Robert "Gene" Christian	District 6	Mitch Sperry	District 20
Wes Lane	District 7	Barbara Kay Christiansen	District 23
Mark Gibson	District 8	Tim Kuykendall	District 21
Robert Hudson	District 9	William Peterson	District 22
Larry Stuart	District 10	Max Cook	District 24
Fredrick Esser	District 11	Thomas Giulioli	District 25
Ernest "Gene" Haynes	District 12	Ray Don Jackson	District 26
Thomas May	District 13	Dianne Barker-Harrold	District 27
Timothy Harris	District 14		

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Caddo County Court Clerk's Office
Canadian County Court Clerk's Office
Carter County Court Clerk's Office
Cherokee County Court Clerk's Office
Cleveland County Court Clerk's Office
Comanche County Court Clerk's Office
Cotton County Court Clerk's Office
Craig County Court Clerk's Office
Custer County Court Clerk's Office
Delaware County Court Clerk's Office
Garfield County Court Clerk's Office
Garvin County Court Clerk's Office
Grant County Court Clerk's Office
Harmon County Court Clerk's Office
Haskell County Court Clerk's Office
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Washington County Court Clerk's Office

A special thank you to the Oklahoma Violence Against Women Act Board through the District Attorney's Council for awarding the Violence Against Women Act Grant funds to this project. Without their support this project would not be possible.

Domestic Violence Fatality Review Board Membership

Office Represented	Member	Designee
Listed Directly In Statute		
Chief Medical Examiner	Fred B. Jordan, M.D.	Ray Rupert
Designee of the Commissioner of the Department of Mental Health and Substance Abuse Services	Domestic Violence & Sexual Assault Division	Julie Young
State Commissioner of Health	Leslie Beitsch, M.D., J.D., Commissioner	Sally Carter
Director of the Criminal Justice Resource Center	K.C. Moon, Director	Carol Furr, J.D.
Chief of Injury Prevention Services, State Department of Health	Sue Mallonee, MPH, R.N., Chief	
Oklahoma Council on Violence Prevention Member	Jeff Hamilton, Chair	Margaret Goldman
Oklahoma State Bureau of Investigation Director	DeWade Langley, Director	David Page, Assistant Director
Appointed by the Commissioner of the Oklahoma Department of Mental Health and Substance Abuse Services (Terms expire June 30, 2002)		
Oklahoma Sheriffs Association	County Sheriff	Jimmie Bruner, Sheriff
Oklahoma Association of Chiefs of Police	Chief of Police	Carolyn Kusler, Chief
Oklahoma Bar Association	Private Attorney	G. Gail Striklin, J.D.
District Attorneys Council	District Attorney	Gene Christian, District Attorney, District 6
Oklahoma State Medical Association	Physician	Howard A. Shaw, M.D.
Oklahoma Osteopathic Association	Physician	Trudy J. Milner, D.O.
Oklahoma Nurses Association	Nurse	Janet Wilson, R.N., Ph.D.†
Oklahoma Coalition Against Domestic Violence and Sexual Assault	Citizen to Represent Domestic Violence Survivors	Terrie Evans
Oklahoma Coalition Against Domestic Violence and Sexual Assault	Citizen	Marcia Smith, OCADVSA Director‡

†Chair
‡ Vice-Chair

Domestic Violence Fatality Review Board Past Members

Office Represented	Designee	Tenure
Chief Medical Examiner	Sharon Asher	July 2001-February 2002
Designee of the Commissioner of the Department of Mental Health and Substance Abuse Services	N. Ann Lowrance	Chair; July 2001-August 2002
Oklahoma Bar Association	Pamela Hartley, J.D.	July 2001-February 2002
Oklahoma State Medical Association	Lori Hansen, M.D.	July 2001- January 2002

The Oklahoma Criminal Justice Resource Center provided staff and administrative support to the Board.

Bill Huntington, M.Ed.*	Coordinator
David Wright, Ph.D.*	Director of Research
Brandi Woods-Littlejohn, MCJ	Project Director
Carrie Duncan	Project Specialist
Kristi Spitzka	Research Assistant
Deidra Upchurch	Research Assistant

*During the year the Director of Research at OCJRC, Dr. David Wright, replaced Bill Huntington as supervisor to the staff.

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December 23, 2003

Dear Reader,

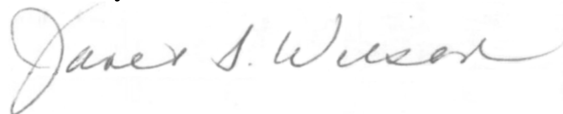
The Oklahoma Domestic Violence Fatality Review Board is pleased to present to the Governor and the citizens of Oklahoma our First Annual Report. On May 31, 2001, HB 1372 created this multidisciplinary board with the mission to reduce the number of domestic violence deaths in the state of Oklahoma. To fulfill this mission the Fatality Review Board reviewed 1998-1999 domestic violence homicides with the goals to:

1. Coordinate and integrate state and local efforts to address fatal domestic violence
2. Collect, analyze, and interpret state and local data on domestic violence deaths
3. Develop a state and local data base on domestic violence deaths
4. Improve protective services for domestic violence victims
5. Improve policies, procedures, and practices within agencies that service domestic violence victims
6. Enter into agreements with other state, local, or private entities as necessary

The deliberative process of case review, data gathering, and data analysis has provided new information and recommendations about the need for training, lethality risk assessment, and improved systems collaboration to prevent domestic violence deaths. During this first year of review, the effectiveness of the review process has been further enhanced by the development of a board "culture of safety" in which the different disciplines and agencies have increasingly dialogued openly and honestly about systems accountability.

We are committed to understanding, intervening, and preventing intimate partner deaths and violence. In addition, we will continue to work for improved communication and coordination among systems to create safer communities within the state of Oklahoma.

Sincerely,



Janet Sullivan Wilson, Ph.D., R.N.
Chair, Oklahoma Fatality Review Board

Supported by the Oklahoma Criminal Justice Resource Center

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The Problem

In light of recent events in the United States, much of our public focus has been trained on international and domestic terrorism within our borders. While there is no discounting the fear and terror these events have generated in the national psyche, domestic terrorism has been occurring within our borders for a long time in a much more personal arena with little notice. Merriam-Webster's Collegiate Dictionary defines terror as 1: a state of intense fear; 2 a: one that inspires fear b: a frightening aspect <the *terrors* of invasion> c: a cause of anxiety d: an appalling person or thing and terrorism as the systematic use of terror, especially as a means of coercion. This definition aptly describes the state in which persons living in a domestic violence situation endure on a daily basis.

- In 2001, family members, boyfriends/girlfriends, and/or member of romantic triangle committed 2,445 (18%) murders in the United States.[1, 2]
- In Oklahoma, 174 (32%) murders fit the definition of domestic violence by statute from 1998-2000.
- The Centers for Disease Control ranked Oklahoma 4th in the nation for rate of intimate partner homicide per 100,000 population for white females and 3rd in the nation for black females.[3]
- In 2000, Oklahoma ranked 19th in the nation for number of females killed by males in single victim, single offender incidents. This is a drop from 8th in 1999.[4]

In 2001, the Federal Bureau of Investigation (FBI) Crime in the United States[1] reported that family members, boyfriends/girlfriends, and/or member of a romantic triangle committed 2,445 (18%) murders in the US.[2] In Oklahoma, there were 542 homicides reported to the Oklahoma State Bureau of Investigation (OSBI) from 1998-2000.[3] Of those, 174, or 32% fit the definition of domestic violence as set forth by the state. Numbers are even higher because not all homicides necessarily get reported to OSBI, and those reported may or may not be categorized as domestic violence homicides. A recent surveillance for homicides among intimate partners in the United States from 1981-1998 by the Centers for Disease Control ranked Oklahoma 4th in the nation for rate of intimate partner homicide per 100,000 population for white females and 3rd in the nation for black females.[4] Until 2000, when Oklahoma fell to 19th, Oklahoma has consistently ranked in the top ten among states in the number of females killed by males in single victim, single offender incidents.[5] This drop in ranking was probably due to the overall drop in Oklahoma's intimate partner homicides during 2000. However, Oklahoma's overall domestic violence homicide rate remained fairly consistent.

Criminal justice professionals - i.e., law enforcement officers, prosecutors and judges - consider domestic violence to be among the most difficult *cases to make*. Many contend that the problem is not with the individuals involved, but with "the system"; others believe just the opposite. There are many factors that lead to both of these views. While domestic violence consists of a series of increasingly more violent episodes, the justice system focuses on each separate incident independently, thus making it difficult for "the system" to see the increasing lethality of the situation. Yet, there is no proven method of predicting when or under what circumstances an

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[1] Federal Bureau of Investigation. (2002). Crime in the United States 2001: Uniform Crime Reports. Washington, DC: U.S. Government Printing Office.

[2] Figures are based on 13,752 murder victims for whom Supplementary Homicide Reports were received.

[3] Oklahoma State Bureau of Investigation. (2002). Crime in Oklahoma: 2001 Uniform Crime Reports. Norman, OK: University Printing Services.

[4] Paulozzi, L.J., Saltzman, L.E., Thompson, M.P., & Holmgreen, P. (2001, October). Surveillance for Homicide Among Intimate Partners—United States, 1981-1998. Morbidity and Mortality Weekly Reports (MMRW) Surveillance Summaries, 50, 1-16.

[5] Violence Policy Center. (2002). When Men Murder Women: An analysis of 2000 data. Washington, DC: Author.

individual abuser will finally kill the victim. Additionally, victims are commonly unwilling or unable to testify, resulting in conflicting or non-existent evidence to support the case. Further, witnesses are most often family members (children) who are under the direct influence of the abuser. Most importantly, Oklahoma has no central repository for gathering detailed case data for analysis of these crimes. With all of these combined, there is little wonder why it is difficult to understand if this is an individual or system problem.

In order to begin to address this problem, the Oklahoma legislature mandated a multi-disciplinary team to systemically review deaths that have occurred in Oklahoma as a direct result of domestic violence. The Board reviews all such deaths as a means to improve methods of prevention, intervention and resolution of domestic violence in Oklahoma. The legislature charged the Board to report annually to key policy and decision makers prior to each legislative session.

Project members represent the multiple disciplines of the stakeholders involved in resolving domestic violence-related homicides. As such, the members are sensitive to the concerns and purposes of the organizations and fields of expertise they represent. Including this array of professionals insures that every effort will be made to maintain the short-term veracity and the long-term credibility of the findings and recommendations. In addition, the spirit of collaboration is considered essential to the success of continuing efforts to reduce domestic violence homicides using a holistic, interlocking approach to prevention, interdiction and resolution.

Mission

The mission of the Oklahoma Domestic Violence Related Fatality Review Board is to reduce the number of domestic violence related deaths in Oklahoma. The Board will perform multi-disciplinary case reviews of statistical data and information derived from disciplines with jurisdiction and/or direct involvement with the case to develop recommendations to improve policies, procedures and practices within the systems involved and between agencies that protect and serve victims of domestic abuse.

Purpose

The Domestic Violence Related Fatality Review Board shall have the power and duty to:

1. Coordinate and integrate state and local efforts to address fatal domestic violence and create a body of information to prevent domestic violence deaths;
2. Collect, analyze and interpret state and local data on domestic violence deaths;
3. Develop a state and local database on domestic violence deaths;
4. Improve the ability to provide protective services to victims of domestic violence who may be living in a dangerous environment;
5. Improve policies, procedures and practices within the agencies that serve victims of domestic violence; and,

6. Enter into agreements with other state, local or private entities as necessary to carry out the duties of the Domestic Violence Fatality Review Board.

History

In 1998, Oklahoma law enforcers responded to more than 21,000 domestic violence calls, reporting 119 domestic violence-related homicides in 1998 and 1999. Given this history, when the Oklahoma Council on Violence Prevention was setting its strategic plan for the following year, one of the projects proposed was an in-depth investigation into domestic violence-related homicides in Oklahoma.

The Council, in partnership with the Oklahoma Criminal Justice Resource Center, proposed legislation in the spring of 2000 to establish a Domestic Violence Fatality Review Board. The goal of the Board is to *reduce the number of domestic violence deaths by performing multi-disciplinary review of data to identify common characteristics of these crimes, then develop recommendations to improve the systems involved to better protect and serve the victims of domestic violence.* However, the session ended just minutes before final action could be completed. Representatives Jari Askins and Darrell Gilbert and Senator Maxine Horner introduced HB 1372 in Spring 2001. The legislation passed with only one "no" in the House. Governor Frank Keating signed the enabling legislation on May 31, 2001. The life of the Board as established by the legislation is from July 1, 2001, through July 1, 2007. (For a full copy of the enabling legislation see Appendix A.)

Concurrent with the introduction of authorizing legislation in 2000, the Council initiated a one-year pilot project to prove the efficacy of a domestic violence-related homicide review process. Initial activities included organizing a multi-disciplinary work group, establishing operational policies, and determining investigative protocols and analysis procedures. In addition, the group was to identify difficulties and challenges encountered through the process.

Once the Governor signed the enabling legislation, work began to establish the membership of the Board as prescribed by the legislation. Seven members are named directly to the Board with no tenure expiration. The remaining nine members are submitted to the Commissioner of the Oklahoma Department of Mental Health and Substance Abuse Services by their respective organizations and are appointed for a two-year term. After the membership was in place, plans for an initial meeting began. The first meeting of the Oklahoma Domestic Violence Fatality Review Board was in September of 2001. At this meeting the Board reviewed the mission, by-laws, policies and procedures established during the Pilot Project. The Board chose to maintain those same documents with few changes (Appendix B). The Board adopted Robert's Rules of Order as the operating procedure to follow regarding meeting procedure.

Specific measures were agreed upon to insure confidentiality of the discussions. First, all case-specific information would be secured under lock and key by project staff, in a separate cabinet from other administrative files. Second, each board and staff member signed *Memorandum of Confidentiality* prior to reviewing any case. Third, case review and discussions would take place during Executive Sessions of regularly scheduled meetings of the board.

The Board met monthly to review cases from 1998 and 1999. These years were chosen to finish the work begun by the Pilot Project work group and to establish a base line for future comparison. Over the course of the year the Board reviewed 53 cases, bringing the database to 75 cases with the inclusion of cases reviewed during the pilot project.

Definitions

Subsequent to creating and assembling the Board, the next step in the process was to determine the data to be collected and construction of a data collection tool. To this end, one of the first tasks undertaken was to select a definition of domestic violence, which could be supported by all members. A review of various efforts across the nation and a review of the literature available revealed a wide range of definitions of domestic violence. Oklahoma statutes contain very specific definitions in the Protection from Domestic Abuse Act and the Domestic Abuse Reporting Act {ref.: Title 22, O.S., §60.1, 1999 Supp. and Title 74, O.S., §150.12B}. Both the pilot project and the legislated Board decided it would be best to use the definition of domestic abuse as defined by Oklahoma statutes.

Protection from Domestic Abuse Act and the Domestic Abuse Reporting Act
{Ref.: Title 22, O.S., §60.1, 1999 Supp. and Title 74, O.S., §150.12B}

1. ***Domestic Abuse*** *means any act of physical harm, or the threat of imminent physical harm which is committed by an adult, emancipated minor, or minor age thirteen (13) years of age or older against another adult, emancipated minor or minor child who are family or household members or who are or were in a dating relationship;*
2. ***Stalking*** *means the willful, malicious, and repeated following of a person by an adult, emancipated minor, or minor thirteen (13) years of age or older, with the intent of placing the person in reasonable fear of death or great bodily injury;*
3. ***Harassment*** *means a knowing and willful course or pattern of conduct by an adult, emancipated minor, or minor thirteen (13) years of age or older, directed at a specific person which seriously alarms or annoys the person, and which serves no legitimate purpose. The course of conduct must be such as would cause a reasonable person to suffer substantial emotional distress, and must actually cause substantial distress to the person. Harassment shall include, but not be limited to, harassing or obscene telephone calls in violation of Section 1172 of Title 21 of the Oklahoma Statutes and fear of death or bodily injury;*
4. ***Family or household members*** *means spouses, ex-spouses, present spouses of ex-spouses, parents, foster parents, children, persons otherwise related by blood or marriage, persons living in the same household or who formerly lived in the same household, persons who are the biological parents of the same child, regardless of their marital status, or whether they have lived together at any time. This shall include elderly and handicapped;*
5. ***Dating relationship*** *means a courtship or engagement relationship. For purposes of this act, a casual acquaintance or ordinary fraternization*

between persons in a business or social context shall not constitute a dating relationship.

Other terms used by the Board include:

- ***Intimate Partners*** refer to:
    - Current spouses
    - Common-law spouses
    - Current non-marital partners
        - Dating partners, including first date (heterosexual or same-sex)
        - Boyfriends/girlfriends (heterosexual or same-sex)
    - Former marital partners
        - Divorced spouses
        - Former common-law spouses
        - Separated spouses
    - Former non-marital partners
        - Former dates (heterosexual or same-sex)
        - Former boyfriends/girlfriends (heterosexual or same-sex)
- ***Domestic violence fatalities*** refer to those homicides caused by, or related to, domestic violence or abuse.
- ***Preventable death*** is one that, with retrospective analysis, might have been prevented given a reasonable intervention (e.g., medical, social, legal, psychological).
- ***Reasonable*** means taking into consideration the condition, circumstances or resources available.

Domestic violence fatality review describes the deliberative process for identification of deaths, both homicide and suicide, caused by domestic violence or abuse, for examination of the systemic interventions into consideration of altered systemic response to avert future domestic violence-related deaths, or for development of recommendations for coordinated community prevention and intervention initiatives to reduce and eradicate domestic violence.

The data collection methods and a discussion of the limitations of the data can be found in Appendix C. A copy of the data collection codebook can be found in Appendix D.

Findings

There were 245 domestic violence homicides in Oklahoma from 1998 to 2000 (Table 1). This means 7.1 Oklahomans per 100,000 die each year due to domestic violence (Figure 1 and Table 2). Of these, 174 (71%) were reported to the Oklahoma State Bureau of Investigation specifically as domestic violence homicides. The others were discovered through direct reports from investigating agencies when information was requested on other cases or through newspaper archive searches.

Table 1. Homicides in Oklahoma.

	Total Homicides	Reported DV Homicides*	Actual DV Homicides*	Actual # of DV Homicide Cases
1998	183	63	84	74
1999	203	63	90	85
2000	156	48	71	67
Total	542	174	245	226

*Count given by number of victims

Figure 1. Domestic Violence Homicides per 100,000 Population*
1998-2000

68%+ Above State Rate

34-67%+ Above State Rate

0-33%+ Above State Rate

*Only Counties with populations over 25,000 are represented on map.

Table 2. Domestic Violence Homicide Rate per 100,000 population, 1998-2000.

Geographic area	Total Population	Size Rank	Homicides	Rate per 100,000	% Above/Below State Rate
Harmon	3,283	76	1	30.5	68%+ above
Cotton	6,614	66	2	30.2	68%+ above
Craig	14,950	45	4	26.8	68%+ above
Haskell	11,792	53	3	25.4	68%+ above
Caddo	30,150	32	6	19.9	68%+ above
Grant	5,144	71	1	19.4	68%+ above
Le Flore	48,109	14	9	18.7	68%+ above
McCurtain	34,402	28	6	17.4	68%+ above
Delaware	37,077	25	6	16.2	68%+ above
Stephens	43,182	20	5	11.6	34-67% above
Love	8,831	63	1	11.3	34-67% above
Garvin	27,210	35	3	11.0	34-67% above
Bryan	36,534	26	4	10.9	34-67% above
Tillman	9,287	61	1	10.8	34-67% above
Comanche	114,996	4	12	10.4	34-67% above
McIntosh	19,456	41	2	10.3	34-67% above
Sequoyah	38,972	23	4	10.3	34-67% above
Kiowa	10,227	60	1	9.8	34-67% above
Tulsa	563,299	2	55	9.8	34-67% above
Adair	21,038	38	2	9.5	0-33% above
Latimer	10,692	57	1	9.4	0-33% above
Ottawa	33,194	30	3	9.0	0-33% above
Noble	11,411	56	1	8.8	0-33% above
Pushmataha	11,667	54	1	8.6	0-33% above
Pontotoc	35,143	27	3	8.5	0-33% above
Okfuskee	11,814	52	1	8.5	0-33% above
Kay	48,080	15	4	8.3	0-33% above
Murray	12,623	50	1	7.9	0-33% above
Oklahoma	660,448	1	52	7.9	0-33% above
McClain	27,740	34	2	7.2	0-33% above
Atoka	13,879	48	1	7.2	0-33% above
Muskogee	69,451	7	5	7.2	0-33% above
Kingfisher	13,926	47	1	7.2	0-33% above
Oklahoma	**3,450,654**		**245**	**7.1**	
Hughes	14,154	46	1	7.1	0-33% below
Cherokee	42,521	21	3	7.1	0-33% below
Carter	45,621	16	3	6.6	0-33% below
Washington	48,996	13	3	6.1	0-33% below
Pottawatomie	65,521	10	4	6.1	0-33% below

Geographic area	Total Population	Size Rank	Homicides	Rate per 100,000	% Above/Below State Rate
Pawnee	16,612	43	1	6.0	0-33% below
Payne	68,190	8	4	5.9	0-33% below
Texas	20,107	39	1	5.0	0-33% below
Canadian	87,697	5	4	4.6	34-67% below
Pittsburg	43,953	19	2	4.6	34-67% below
Osage	44,437	18	2	4.5	34-67% below
Seminole	24,894	37	1	4.0	34-67% below
Custer	26,142	36	1	3.8	34-67% below
Jackson	28,439	33	1	3.5	34-67% below
Garfield	57,813	11	2	3.5	34-67% below
Lincoln	32,080	31	1	3.1	34-67% below
Mayes	38,369	24	1	2.6	34-67% below
Okmulgee	39,685	22	1	2.5	34-67% below
Wagoner	57,491	12	1	1.7	68%+ below
Creek	67,367	9	1	1.5	68%+ below
Rogers	70,641	6	1	1.4	68%+ below
Cleveland	208,016	3	1	0.5	68%+ below
Alfalfa	6,105	67	0	0.0	NA
Beaver	5,857	70	0	0.0	NA
Beckham	19,799	40	0	0.0	NA
Blaine	11,976	51	0	0.0	NA
Choctaw	15,342	44	0	0.0	NA
Cimarron	3,148	77	0	0.0	NA
Coal	6,031	69	0	0.0	NA
Dewey	4,743	72	0	0.0	NA
Ellis	4,075	73	0	0.0	NA
Grady	45,516	17	0	0.0	NA
Greer	6,061	68	0	0.0	NA
Harper	3,562	74	0	0.0	NA
Jefferson	6,818	65	0	0.0	NA
Johnston	10,513	59	0	0.0	NA
Logan	33,924	29	0	0.0	NA
Major	7,545	64	0	0.0	NA
Marshall	13,184	49	0	0.0	NA
Nowata	10,569	58	0	0.0	NA
Roger Mills	3,436	75	0	0.0	NA
Washita	11,508	55	0	0.0	NA
Woods	9,089	62	0	0.0	NA
Woodward	18,486	42	0	0.0	NA

As of August 2002, the Domestic Violence Fatality Review Board had reviewed 75 of the 159 cases from 1998 and 1999. The 75 cases represent 88 victims and 86 perpetrators. The findings leading to their recommendations are reported below:

Table 3 provides demographic characteristics of the victims and perpetrators. On average, victims were 35 years old and perpetrators were 38 years of age. The youngest victim was less than a day old, the eldest 87. Most of the victims were white (74%), followed by Blacks (19%) and Native Americans (7%). Nearly 5% of victims were of Hispanic or Latino origin. The youngest perpetrator was 13 years of age; the eldest was 75 years old. The majority of perpetrators were white (78%), followed by Blacks (17%) and Native Americans (5%). Nearly 5% of perpetrators were of Hispanic or Latino origin. Overall, the majority of homicides were homogeneous, only 6 (8%) were interracial homicides.

Table 3. Characteristics

	Victims				Perpetrators			
	Female (N=48)		Male (N=40)		Female (N=22)		Male (N=64)	
Age (average, in years)	35.19		34.13		36.01		38.08	
Race								
White	39	81%	26	65%	18	82%	49	77%
Black	6	13%	11	28%	4	18%	11	17%
Native American	3	6%	3	8%			4	6%
Of Hispanic or Latino Origin	1	2%	3	8%			4	6%
Previous Domestic Violence	31	65%	19	48%	13	59%	33	52%
Acute/Chronic medical conditions	10	21%	6	15%	7	32%	14	22%
Mental Health History	5	10%	3	8%	8	36%	14	22%
Pregnant at time of death	1	2%			1	5%		

One victim was reported to be pregnant at the time of death. There was documented history of domestic violence for 57% of the victims. Eighteen percent of victims had a known history of acute and or chronic medical conditions and 9% of victims had a known history of mental and/or emotional problems. Of those victims with known medical and/or mental/emotional conditions, 10% had seen a doctor or counselor within a week of their homicide. One perpetrator was reported to be pregnant at the time of the homicide. Fifty-three percent of perpetrators had a documented history of domestic violence. Nearly a quarter of perpetrators had a known history of acute and or chronic medical problems and just over a quarter of perpetrators had a known history of mental and or emotional problems; 9% had seen their practitioner within a week of the homicide.

Table 4. ODMHSAS Contacts

	Victims		Perpetrators	
Ever had contact with ODMHSAS	12	16%	15	20%
Alcohol/Drug Center for Alcohol Abuse	3		7	
Alcohol/Drug center for Substance Abuse	1		13	
Community Mental Health Center - Alcohol Abuse			3	
Community Mental Health Center - Developmental Disorder			3	
Community Mental Health Center - Emergency Order of Detention	1		3	
Community Mental Health Center - Mood Disorder	10		7	
Community Mental Health Center - Other Non-Psychotic	3		3	
Community Mental Health Center - Other Psychotic			1	
Community Mental Health Center - Schizophrenia	1		2	
Community Mental Health Center - Substance Abuse	2		2	
Dual Diagnosis Treatment Center			1	
State hospital - reason unknown			1	
State Hospital - schizophrenia			1	

*8 Victims had multiple contacts with ODMHSAS

*12 Perpetrators had multiple contacts with ODMHSAS

Twelve victims (16%) and fifteen perpetrators (20%) had at least one known contact with the Department of Mental Health and Substance Abuse Services prior to their death (See Table 4). Although 95% of victims had domestic violence services available within their county of residence, only two victims were known to have contacted domestic violence services and only one victim was known to have stayed in a domestic violence shelter. One perpetrator contacted domestic violence services and one was reported to have stayed in a domestic violence shelter.

Alcohol and drug use was higher among perpetrators (60%) than victims (37%). Eleven percent of victims had received substance abuse treatment prior to their death. A fifth of perpetrators had received substance abuse treatment at least once prior to the homicide. Over two-fifths of both victims (45%) and perpetrators (41%) were known to be intoxicated at the time of the homicide (See Table 5).

Table 5. Substance use and treatment

	Victims		Perpetrators	
Known to regularly use drugs or alcohol at the time of death?	28	37%	45	60%
Received alcohol/substance abuse treatment	8	11%	15	20%
Positive Toxicology report at death (P:N=17)	34	45%	6	35%
If alive, did the perpetrator appear intoxicated/was intoxicated at time of death event? (N=58)			26	45%
Of all Perpetrators, number that appeared intoxicated/were intoxicated at time of death event			32	43%

In 53% of the cases the perpetrator and victim were cohabitating. A current or former intimate partner killed half of all the victims in the reviewed cases (Table 6). Forty-three percent of victims had children under the age of eighteen living in their home; of those children 27% were present at the time of death. Of the victims with children, 23% had children with the perpetrator and 40% had children with a former partner. There were witnesses in 60% of the cases reviewed. Adults witnessed the homicide in 47% of the cases, with one to 17 adult witnesses in any of the cases. Children either saw or heard 39% of the slayings and in 48% of the cases they were eyewitnesses to the event. In cases with child witnesses anywhere from one to four children witnessed the homicide, and ranged in age from less than one year to 17 years of age with an average age of 8 years old.

Table 6. Perpetrators relationship to Victim

Relationship	N	%	Relationship	N	%
boyfriend/girlfriend	15	16%	in-law	6	6%
common law spouse	4	4%	former in-law	1	1%
spouse	18	19%	grandchild	3	3%
estranged spouse	4	4%	grandchild's boyfriend/girlfriend	3	3%
former boyfriend/girlfriend	3	3%	other family	3	3%
former common law spouse	2	2%	Other**	4	4%
former spouse	2	2%	Parent/step-parent	7	7%
former partner/current partner*	8	8%	parent's boyfriend/girlfriend	6	6%
child/step-child	5	5%	sibling	2	2%

+Total relationships does not equal number of victims as some perpetrators had multiple relationships with victims.
*This category includes those relationships where a person's current/former partner murders their current/former partner, ie. New husband murders wife's ex-husband
** This category includes roommates and others involved in committing homicide that may not have familial relationship to victim, ie. Friends of perpetrator who helped commit murder.

Out of the 17 cases in which the victim and perpetrator had children in common, the victim and perpetrator were living separately in 10 of those cases. In seven of those ten cases the children were under the age of eighteen. Additionally, in three cases there was a joint custody agreement between either the perpetrator or victim and a new partner (for example, victim has joint custody with ex-wife, ex-wife's new husband is the perpetrator). Overall, in ten cases there were joint

custody arrangements.[6] In three of the cases the perpetrator took the children and hid them from the victim for a period of time, in essence kidnapping the child. In three of the cases the perpetrator used the children to pass threatening messages to the victim. And five of the homicides occurred during a child exchange (Table 7).

Table 7. Joint Custody

Cases where joint custody agreement existed	10	100%
Cases where perpetrator kidnapped children	3	30%
Perpetrator passed threatening messages to victim through children	3	30%
Homicide occurred during child exchange	5	50%

Firearms were used in 59% of the reviewed homicides (See Table 8). The majority of all of the homicides occurred at the victim's residence (67%), with the majority of those occurring in the bedroom (32%) or the living room (29%).

Table 8. Weapons used & location of death event

No known weapons or bodily force	3	4%	Highway	1	1%
BODILY FORCE	12	16%	City Street	4	5%
BLUNT OBJECT	2	3%	Rural Road	1	1%
CUTTING or PIERCING instrument	7	9%	Public Driveway/Parking area	2	3%
LONG GUN (e.g., shotgun, rifle)	9	12%	Private Driveway/Parking area	2	3%
HANDGUN	34	45%	Residence of Victim	50	67%
FIREARM, TYPE UNKNOWN	1	1%	Other Residence	3	4%
Another Type of Weapon	7	9%	Victim's Place of Employment	1	1%
			Residence of Perpetrator	10	13%
			Motel/Hotel	1	1%

Eighty-five percent of victims and 72% of perpetrators did not have a prior conviction record (Table 9). And 75% of victims and 55% of perpetrators had never been arrested before. Of those with prior arrest and conviction records the average number of convictions for victims was 3.7 with a range of one to 22; and 4.3 for perpetrators, with a range of one to thirty. Driving under the influence (DUI) was the primary crime for which both victims and perpetrators had been arrested and/or convicted. Thirteen victims had at least one prior arrest for DUI, with seven of those leading to a conviction. Eighteen perpetrators had at least one prior arrest for DUI, with ten of those arrests leading to conviction.

Table 9. Prior convictions and arrests.

	Victims		Perpetrators	
Any prior conviction	17	23%	33	44%
Prior felony conviction	11	15%	21	28%
Prior misdemeanor conviction	7	16%	22	29%
Prior arrest	19	25%	34	45%
On probation or parole at the time of death event	4	5%	11	15%

Victim protection orders (VPO) had been utilized in 21% of the reviewed cases. The breakdown of who filed the protection order can be seen in Table 10. In half of the cases where a protection order did exist, the defendant violated the VPO. The average number of violations was 4.36 with a range of one to eighteen. The outcomes of those

Table 10. Victim Protection Orders & Stalking

The Victim had filed a VPO against the perpetrator	8	11%
The Perpetrator had filed a VPO against the victim	4	5%
A relative of the victim had a VPO filed against the Perpetrator	6	8%
The victim had told others the perpetrator was stalking him/her	7	9%

[6] 7 court ordered, 3 mutually agreed by involved parties

violations can be seen in Table 11. Seven victims told others that the perpetrator was stalking them prior to the death event. The victims reported stalking behavior to law enforcement (4), family (5), friends (3), employer (1), and the court through filing for a victim protection order (1).

Table 11. Victim protection order outcomes.

Case ID	Type of Victim Protection Order in existence	# times VPO had been violated	VPO Active at time of death	Outcome
980010	Permanent	12	Yes	Never reported any violations to police
980016	Ex Parte		No	Filed in 1990, dropped.
980022	Ex Parte		No	Dropped.
980031	Temporary		Yes	VPO b/t P and V's ex-wife. Had not been served.
980041	Permanent	5	Yes	VPO b/t P and V's daughter. She had reported 4 violations to law enforcement, DA decline to file.
980046	Permanent		No	Dropped.
980050	Permanent	3	Yes	violations occurred 3 months prior and were dismissed by court
980052	Permanent	18	Yes	V repeatedly contacted police about violations. They told her she needed to follow up with DA. P was calling her repeatedly from county jail while he was there for violating the VPO. She reported this to police who told her to tell the sheriff what was happening.
980055	Permanent	2	Yes	VPO b/t V and P's wife (V's ex-wife). Violations reported but not enforced due to joint custody order with no restrictions on calls or V coming by residence to check on daughter.
980056	Ex Parte		No	VPO b/t P and V's wife (P's ex-girlfriend). Dismissed Failure To Appear
980066	Permanent		Yes	
990017	Temporary		No	VPO b/t P and V's mother. Dropped.
990019	Temporary	1	Yes	V reported violation to police (used visitation w/children to have them deliver threat letter to V). Warrant issued for arrest for violation of VPO. Sheriffs office had not executed service at time of death 20 days later, nor had they forwarded warrant to local law enforcement
990020	Permanent	1	No	VPO was filed in another state in 1991 (good for 1 year) V violated it one week later - outcome unknown. Another was filed in 1993, dismissed-FTA. Since then V & P had moved to OK and cohabitated.
990044	Permanent	2	Yes	2 violations reported to police. First reported when V entered home 2 years after service of VPO. At time P made stmt that V continually entered her home. Reported 2nd violation while V was awaiting trial for first violation. He called P 14 times from County Jail.
990072	Ex Parte		No	Never served, court dismissed FTA

Law enforcement had responded to domestic disturbances in at least 40% of the cases. For the cases in which they responded, the average number of responses was 3.08 with a range of one to eighteen documented responses. This number could potentially be higher as it only counts documented responses. If an officer responded, but did not fill out a report or if the report was not included in the documentation received from law enforcement it is unaccounted for in this number.

Table 12. Who knew?

Family	27	63%
Law Enforcement	24	56%
Friends	19	44%
Court - VPO	9	21%
Neighbor	6	14%
Medical/Doctor	4	9%
DHS	3	7%
DV services	2	5%
Employer/Co-workers	2	5%
Attorney	1	2%
Court	1	2%
Mental Health	1	2%

*32 Victims had reported abuse to more than one party.

In many cases several people were aware of the violence occurring. Someone else knew of the ongoing domestic violence in 57% of the reviewed cases. Of those, the majority who were aware of the violence were family members (63%), law enforcement (56%), and friends (44%). Table 12 reveals the other people and entities that had contact with the victim and were aware of the violence. In 32 cases, more than one person or entity was aware of the situation.

As to the outcome of the cases, charges were filed in 72% of the cases. Table 13 details the charges filed against the perpetrators, and those they were convicted of committing. Seventeen perpetrators had more than one charge filed against them, and fifteen were convicted of more than one offense. Convictions were attained in 87% of the cases that were filed. Four (7%) were acquitted of the charges and three (6%) died before the completion of prosecution. It took an average of one year and two months to complete each case from the date of death to conviction, with a range of 88 days to 3 years and six days. Of those convicted, two-fifths were found guilty by a jury (40%), over a third pled guilty (34%), nearly a fifth pled Nolo Contendere (17%), three were found guilty by a judge (6%) and one entered a blind plea (2%).

Table 13. Charges

	Filed		Convicted	
Conspiracy to Commit Murder I			1	1%
Manslaughter I	3	4%	16	20%
Murder I	45	60%	20	16%
Murder II	6	8%	10	9%

Eighty-five percent were sentenced to prison, 11% received a split prison and probation sentence, one received probation only and one was sentenced as a youthful offender under the Office of Juvenile Affairs (Table 14). The average sentence is 21.28 years, not including those sentenced to life or life without parole. Sentences ranged from 4 years to 91 years. Eight were sentenced to life in prison and fourteen were sentenced to life without parole.

Table 14. Sentences.

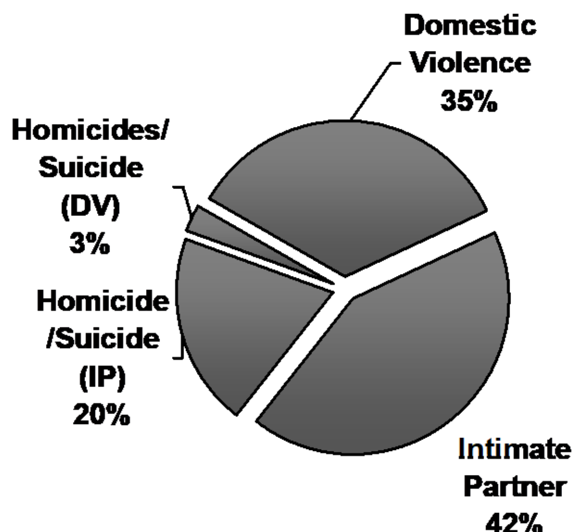
	Female		Males	
Prison only	11	85%	29	85%
Prison and Probation	2	15%	3	9%
Probation only			1	3%
OJA Youthful Offender			1	3%
Average sentence*	20.9	years	21.5	years
Life	4	31%	4	12%
Life without parole	1	8%	13	38%

*Average excludes life and life without parole sentences.

For a complete review of all of the data collected see Appendix E.

Intimate Partner Homicide

Of the 75 1998-1999 cases reviewed, 47 (62%) were committed by intimate partners (IP) and 28 (38%) were committed by other family members (DV). Of the 28 Domestic Violence Homicides, 2 were Homicide/Suicide cases. Of the 47 Intimate Partner Homicides, 15 were Homicide/Suicide cases.



Intimate Partner Case Characteristics

The Board held a great interest in the cases involving intimate partner relationships and requested additional analysis on this subset of cases. The findings are reported as follows.

Tables 15-16 depict demographic characteristics and relationships of the victims and perpetrators. On average, the victim's age was 41.5 years, with a range of 15.8 to 70.3 years. Perpetrators average age was 41.2 years, with a range of 15.1 to 75 years. Most victims were female (72%), and most perpetrators were male (70%). Most victims and perpetrators were White (79%), and Non-Hispanic/Latino (98%). In a substantial number of cases the levels of education were unknown (66% victims, 36% perpetrators). The largest category of known education level among victims was "Some College" at 11%. For perpetrators,

Table 15. Cohabitation & Status of Relationship

		Female (N=34)		Male (N=13)	
Victim was cohabitating with the Perpetrator		20	59%	8	62%
Was the victim attempting to or in the process of leaving the perpetrator at the time of death event?	No	9	26%	8	62%
	Yes	5	15%		
	Unknown	6	18%		
Victim was NOT cohabitating with the Perpetrator		14	41%	5	38%
Was the victim attempting to or in the process of leaving the perpetrator at the time of death event?	No	3	9%	3	23%
	Yes	11	32%	1	8%
	Unknown			1	8%

Table 16. Characteristics

	Victims				Perpetrators			
	Female (N=34)		Male (N=13)		Female (N=14)		Male (N=33)	
Age (average, in years)					36.01		38.08	
Race								
White	29	85%	8	62%	10	71%	27	82%
Black	2	6%	5	38%	4	29%	4	12%
Native American	3	9%					2	6%
Of Hispanic or Latino Origin	1	3%					1	3%
Separated, Divorce pending	7	21%	1	8%	1	7%	7	21%
Married, Living Separately	1	3%	1	8%	1	7%	1	3%
Divorced (not remarried)	5	15%	2	15%	4	29%	3	9%
Married	11	32%	4	31%	3	21%	10	30%
Common Law Married	3	9%	1	8%	1	7%	3	9%
Single/Never Married	4	12%	2	15%	3	21%	6	18%
Widowed			1	8%	1	7%	3	9%
Unknown/not stated	3	9%	1	8%				
Spouse	15	44%	5	38%	5	36%	15	45%
Common-Law Spouse	2	6%	1	8%	1	7%	2	6%
Divorced Spouse	2	6%					2	6%
Former Common-Law Spouse	1	3%					1	3%
Separated Spouse or Common-Law Spouse	3	9%					3	9%
Girl/Boy Friend	9	26%	6	46%	6	43%	9	27%
Former Girl/Boy Friend	2	6%	1	8%	2	14%	1	3%
$15,000 or below	12	35%	3	23%	9	64%	10	30%
$15,001 to $25,000	4	12%			1	7%	5	15%
$25,001 to $50,000	4	12%	2	15%	1	7%	4	12%
$100,000 or above			1	8%				
Unknown	14	41%	7	54%	3	21%	14	42%
Less than High School	3	9%			5	36%	5	15%
High School Graduate	2	6%	2	15%	3	21%	5	15%
Vocational/Technical	1	3%					2	6%
Some College	5	15%			1	7%	5	15%
Associate Degree			1	8%				
Bachelor's Degree	2	6%			2	14%		
Graduate Degree					1	7%	1	3%
Unknown	21	62%	10	77%	2	14%	15	45%

the level of education was “Less than High School” in 21% of cases. When socioeconomic status was known, most victims (32%) and perpetrators (40%) made $15,000 or below per year.

Most victims (32%) and perpetrators (28%) were married at the time of the death event, and 43% of perpetrators were spouses. The majority (60%) of victims and perpetrators were cohabitating. The average length of time the victim and perpetrator were in a relationship was 149.4 months or 12.45 years, with a range of 3 months to 51.2 years. Thus victims were typically poor, middle aged, white females who were married to and living with the perpetrator. Generally, perpetrators had similar characteristics to the victims, with the main exception being that they were male.

A significant number of victims (77%) and perpetrators (60%) had no known criminal convictions (Table 17). The minimum number of convictions for victims was 0, and the maximum was 22. The minimum number of convictions for perpetrators was 0, and the maximum number was 30. Four percent of victims were serving a prior sentence at the time of the death event (Table 18).

Table 17. Total Number of Prior Convictions (Felony and Misdemeanor)

	Victims		Perpetrators	
0	36	77%	28	60%
1-2	3	6%	8	17%
3-5	6	13%	8	17%
7+	2	4%	3	6%

Fifteen percent of perpetrators were serving a prior sentence at the time of the death event.

Table 18. On Probation/Parole at the time of Death

	Victims		Perpetrators	
No	7	15%	12	26%
Yes	2	4%	7	15%
Unknown	2	4%		
Not Applicable	36	77%	28	60%

Among the victims, 43% were known to use drugs/alcohol, while 51% of perpetrators were known to use drugs/alcohol (Table 19). For victims, 23% had no record of ever receiving substance abuse treatment; 38% of perpetrators did not receive substance abuse treatment. A substantial number of victims and perpetrators had unknown medical histories (Table 20). When medical histories were known, 23% of victims had acute/chronic medical problems, while 34% of perpetrators had acute/chronic medical problems. A significant number of victims and perpetrators had no mental health history. For those whose mental health history was available, 13% of victims and 23% of perpetrators had a history of psychological/ emotional issues.

Table 19. Substance use and treatment

	Victims		Perpetrators	
Known to use drugs/alcohol at time of death				
Yes	20	43%	28	57%
No	7	15%	5	11%
Unknown	20	43%	14	32%
# times received drug/alcohol treatment				
0	11	23%	17	36%
1-4 times	6	13%	8	17%
Unknown if needed	19	40%	13	28%
Unknown if received	5	11%	5	11%
Not applicable, no history of use	6	13%	4	9%

Table 20. Medical and Mental Health

History of Acute/Chronic Medical Condition	Victims		Perpetrators	
No	15	32%	12	26%
Yes	11	23%	16	34%
Unknown	21	45%	19	40%
History of Psychological/ Emotional Issues				
No	38	81%	32	68%
Yes	6	13%	11	23%
Unknown	3	6%	4	9%

Table 21 displays the victims' and perpetrators' violence histories. Among the victims 14.9% had a history of committing violence other than domestic violence, while 30% of perpetrators had a history of committing other types of violence. There is a large difference between victims and perpetrators with regards to history of committing domestic violence. Indeed, 23% of victims and 64% of perpetrators had a history of committing domestic violence. Among perpetrators, only one was ever sentenced to a Batterer's Intervention Program. The completion of the program is unknown.

Table 21. Violence History

	Victims		Perpetrators	
History of committing violence other than Domestic Violence?				
No	23	49%	14	30%
Yes	7	15%	14	30%
Possible (one source)	1	2%	1	4%
Unknown	16	34%	18	38%
History of Committing Domestic Violence?				
No	15	32%	7	15%
Yes	11	23%	30	64%
Possible (one source)	6	13%	2	4%
Unknown	15	32%	8	17%

The Perpetrator made death threats against the Victim or someone known to the Victim prior to the death event in 34% of the cases, while the victim made death threats against the perpetrator in only 4% of the cases (Table 22). For a

Table 22. Ever made death threat against the Perpetrator/Victim prior to the death event?

	Victims		Perpetrators	
No	21	45%	8	17%
Yes	2	4%	16	34%
Possible (one source)	1	2%	2	4%
Unknown	23	49%	21	45%

complete look at the lethality factors related to the intimate partner homicides see Appendix F.

Table 23. Death Event Characteristics

Day of Death Event		
Monday	7	15%
Tuesday	4	9%
Wednesday	5	11%
Thursday	5	11%
Friday	10	21%
Saturday	11	23%
Sunday	5	11%
Time of Death Event		
Pre-Dawn (1:00 a.m.-5:59 a.m.)	11	23%
Morning (6:00 a.m.- 10:59 a.m.)	6	13%
Mid-day (11:00 a.m.- 3:59 p.m.)	3	6%
Evening (4:00 p.m.- 8:59 p.m.)	12	26%
Night (9:00 p.m.- 12:59 p.m.)	10	21%
Unknown	5	11%
Scene of Death Event		
Highway	1	2%
City Street	1	2%
Rural Road	1	2%
Public Driveway/Parking Area	2	4%
Residence of Victim	33	70%
Other Residence	2	4%
Victim's Place of Employment	1	2%
Residence of Perpetrator	5	11%
Other	1	2%
If death event occurred in residence or workplace, where?		
Living Room/Main Area	16	34%
Office/Study	1	2%
Bedroom	16	34%
Hallway	1	4%
Entryway	1	4%
Front Yard	1	4%
Other	1	4%
Not Applicable	6	13%

The most common day of death event occurrence was Saturday with 23% of deaths occurring then, followed by Friday with 21% (Table 23). Most death events (26%) occurred in the evening between 4:00 p.m. and 8:59 p.m.; followed by early morning hours from 1:00 a.m. to 5:59 a.m. (23%). The majority of deaths occurred in the Victim's Residence (70%) and in the Living Room/Main Room (34%) or Bedroom (34%). The weapon of choice in 64% of the homicides was a firearm (Table 24). Drug and/or alcohol use by the victim, perpetrator or both was associated with the death event in 62% of the cases. In 47% of the intimate partner homicides there were witnesses to the death event; in 23% of the cases a child was a witness to the death event.

Table 24. Mechanism/Cause of Death

Cut/Pierce	5	11%
Fire/Burn – Fire/Flame	1	2%
Firearm	30	64%
Poisoning	1	2%
Struck By/Against	1	2%
Strangulation	2	4%
Automobile	1	2%
Head Trauma	3	6%
Undetermined	3	6%

Fifteen percent of victims had filed a Victim Protection Order (VPO) against their perpetrator (Table 25). Eleven percent of perpetrators filed a VPO against their victim. Table 26 displays the status of the VPOs at the time of the death event. Of the VPOs filed, 82% had been served prior to the death event, and over half were active at the time of death. The VPOs had been violated in over half of the cases, the number of violations ranged from one to eighteen.

Table 25. Victim Protection Order Filing

Victim filed VPO against Perpetrator	7	15%
Perpetrator filed VPO against Victim	5*	11%

*In one case the judge ordered a mutual protective order.

Table 26. Of the filed Victim Protection Orders (N=11)

	VPO had been served		VPO was active		VPO had been violated	
No	1	9%	5	45%	1	9%
Yes	9	82%	6	55%	6	55%
Unknown	1	9%			4	36%

In 72% of the cases, at least one other person or entity had knowledge of the existence of domestic violence/sexual assault between the perpetrator and victim. Law enforcement knew of the domestic violence/sexual assault in 63% of the cases, followed by family awareness in 57% of the cases (Table 27).

Table 27. Who knew?*

No evidence of DV/SA	6	13%
Unknown	6	13%
Medical	5	14%
Social Services	1	3%
Law Enforcement	22	63%
Family Court/VPO	9	26%
Domestic Violence Program	2	6%
Family	20	57%
Neighbors	3	9%
Friends	17	49%
Co-worker/Employer	2	6%

*In 35 cases at least one entity/person knew of DV/SA between victim and perpetrator. The percentages are figured based on the number of cases in which someone else knew.

The following tables summarize charges, sentences, and dispositions of cases. Criminal charges were filed in 62% of the cases; three cases were determined to be self-defense and in 32% of the cases the perpetrator committed suicide. Murder I charges were filed in 57% of the cases (Table 28). Of those charged, 90% were convicted and sentenced to prison. Thirty percent of perpetrators were convicted of Murder I, and 15% were convicted of Manslaughter I. A jury found 23% of perpetrators guilty. Of those convicted, 21% received Life without Parole for their crime (Table 29). The average sentence length was 17.3 years not including the life and life without parole sentences.

Table 28. Charges

	Charges Filed		Charges Convicted Of	
Manslaughter I	1	2%	7	15%
Murder I	27	57%	14	30%
Murder II	1	2%	5	11%
Unknown OJA			1	2%

Table 29. Sentencing

4 years	1	2%
10 years	3	6%
12 years	1	2%
15 years	2	4%
27 years	1	2%
35 years	2	4%
Life	6	13%
Life w/o Parole	10	21%

Homicide-Suicide

Of the 75 1998-1999 cases reviewed, 17 were Murder/Suicides (22%).

Table 30. Homicide/Suicide Characteristics

	Victims		Perpetrators	
Age (average, in years)	40.07		44.89	
Female	15	88%		
Male	2	12%	17	100%
Race				
White	14	82%	14	82%
Black	2	12%	2	12%
Native American	1	6%	1	6%
Separated, Divorce pending	5	29%	5	29%
Married, Living Separately	1	6%	1	6%
Married	4	24%	5	29%
Common Law Married	3	18%	4	24%
Single/Never Married	3	18%	1	6%
Unknown/not stated	1	6%	1	6%
Spouse	9	53%	9	53%
Common-Law Spouse	2	12%	2	12%
Separated Spouse or Common-Law Spouse	2	12%	2	12%
Girl/Boy Friend	1	6%	1	6%
Former Girl/Boy Friend	1	6%	1	6%
Child/Step-Child	2	12%		
Parent/Step-parent			2	12%
$15,000 or below	4	24%	3	18%
$15,001 to $25,000	1	6%	1	6%
$25,001 to $50,000	4	24%	4	24%
Unknown	8	47%	9	53%
Less than High School	1	6%	1	6%
High School Graduate	2	12%		
Some College	4	24%	3	18%
Bachelor's Degree	2	12%		
Graduate Degree			1	6%
Unknown	8	47%	12	71%

Table 30 displays some of the general characteristics of the victims and perpetrators of homicide/suicide cases reviewed by the Board. Victims were predominately female; all of the victims in the intimate partner homicide-suicides were female. All perpetrators of homicide-suicide were male. The average age of victims was 40 years of age, and 45 years of age for perpetrators. The majority of both victims and perpetrators were white, and none were of Hispanic or Latino Origin. Twenty-nine percent of victims were separated from their spouse awaiting final divorce proceedings. Over half of the perpetrators were the victims' spouses. When socio-economic level was known both victims and perpetrators most often fell into the $25,001 to $50,000 range of annual income. Similarly, both victims and perpetrators were known to have some college education when education level was known. The average length of the relationship between victims and perpetrators was 23.5 years, with a range of one year to 51.2 years.

Table 31. Cohabitation & Status of Relationship

	Victim was attempting to or in the process of leaving the perpetrator at the time of death event							
	Yes		No		Unknown		Total	
Victim was cohabitating with the perpetrator	2	12%	4	24%	2	12%	8	47%
Victim was NOT cohabitating with the perpetrator	9	53%					9	53%
Total	11	65%	4	24%	2	12%		

Over half of the victims were not cohabitating with the perpetrator at the time of the death event. Further, 65% were in the process of leaving the perpetrator at the time of the homicide-suicide (See Table 31.)

A significant number of victims (94%) and perpetrators (88%) had no known criminal convictions (Table 32). In fact, only one victim had any prior convictions; that victim had four prior convictions for obtaining a controlled dangerous substance by forgery or fraud. The minimum number of convictions for perpetrators was 0, and the maximum number was 4. Only two perpetrators had any prior convictions. One had a prior conviction for aggravated assault-family; the other had convictions for reckless driving (reduced from DUI), two convictions for carrying a concealed weapon, and one for disorderly conduct (reduced from assault and battery). Only one victim was on probation at the time of the death event. None of the perpetrators were serving a prior sentence at the time of the death event.

Table 32. Total Number of Prior Convictions (Felony and Misdemeanor)

	Victims		Perpetrators	
No Priors	16	94%	15	88%
1 Prior			1	6%
4 Priors	1	6%	1	6%

Table 33. Substance use and treatment

	Victims		Perpetrators	
Known to use drugs/alcohol at time of death				
Yes	1	6%	7	41%
No	6	35%	3	18%
Unknown	10	59%	7	41%
# times received drug/alcohol treatment				
0	2	12%	7	41%
1 time			1	6%
Unknown if needed	9	53%	6	35%
Not applicable, no history of use	6	35%	3	18%

Among the victims, only one was known to regularly use drugs and/or alcohol at the time of death, while 41% of perpetrators were known to regularly use drugs and/or alcohol (Table 33). None of the victims were known to have ever received substance abuse treatment; only one perpetrator was ever known to receive substance abuse treatment. A substantial number of victims and perpetrators had unknown medical histories (Table 34). When medical histories were known, 18% of victims had acute/chronic medical conditions, while 29% of perpetrators had acute/chronic medical conditions. None of the victims were known to have any history of psychological or emotional problems, and two perpetrators were known to have such conditions.

Table 34. Medical and Mental Health

History of Acute/Chronic Medical Condition	Victims		Perpetrators	
No	5	29%	4	24%
Yes	3	18%	5	29%
Unknown	9	53%	8	47%
History of Psychological/ Emotional Issues				
No	16	94%	14	82%
Yes			2	12%
Unknown	1	6%	1	6%

Table 35. Violence History

	Victims		Perpetrators	
History of committing violence other than Domestic Violence?				
No	12	71%	6	35%
Yes			3	18%
Possible (one source)				
Unknown	5	29%	8	47%
History of Committing Domestic Violence?				
No	11	65%	5	29%
Yes			6	35%
Possible (one source)			1	6%
Unknown	6	35%	5	29%

Among the victims none had a known history of committing violence other than domestic violence; further none had a history of committing domestic violence (Table 35). Eighteen

percent of perpetrators had a history of committing other types of violence and 41% had a history of committing domestic violence. None of the perpetrators were ever known to have been sentenced to a Batterer's Intervention Program.

Table 36. Ever made death threat against the Perpetrator/Victim prior to the death event?

	Victims		Perpetrators	
No	13	77%	5	29%
Yes			7	41%
Possible (one source)			1	6%
Unknown	4	24%	4	24%

Table 36 shows that 47% of the time, the Perpetrator made death threats against the Victim or someone known to the Victim prior to the death event, while the victims were never known to have made death threats against the perpetrator. In five (29%) of the cases the perpetrator had threatened suicide prior to the death event. In two of the cases, the perpetrator had been violent to the children in the home as well as the victim.

The most common day of occurrence was Monday with 29% of deaths occurring then, followed by Friday with 24%. Most death events (35%) occurred in the morning between 6:00 a.m. and 10:59 a.m.; followed by evening hours from 4:00 p.m. to 8:59 p.m. (29%). The majority of deaths occurred in the Victim's Residence (65%) and in the Living Room/Main Room (41%) followed by the Bedroom (29%). Thirty-five percent of the homicide-suicides occurred in communities with a population of 2,501 to 10,000 people (See Table 37).

Table 37. Death Event Characteristics

Day of Death Event		
Monday	5	29%
Tuesday	1	6%
Wednesday	3	18%
Friday	4	24%
Saturday	3	18%
Sunday	1	6%
Time of Death Event		
Pre-Dawn (1:00 a.m.-5:59 a.m.)	1	6%
Morning (6:00 a.m.- 10:59 a.m.)	6	35%
Mid-day (11:00 a.m.- 3:59 p.m.)	2	12%
Evening (4:00 p.m.- 8:59 p.m.)	5	29%
Night (9:00 p.m.- 12:59 p.m.)	1	6%
Unknown	2	12%
Scene of Death Event		
City Street	1	6%
Rural Road	1	6%
Public Driveway/Parking Area	1	6%
Residence of Victim	11	65%
Other Residence	1	6%
Victim's Place of Employment	1	6%
Residence of Perpetrator	1	6%
If death event occurred in residence or workplace, where?		
Living Room/Main Area	7	41%
Office/Study	1	6%
Bedroom	5	29%
Front Yard	1	6%
Not Applicable	3	18%
Population of death event location		
1 - 2,500 people	4	24%
2,501 - 10,000 people	6	35%
10,001 - 100,000 people	2	12%
Over 100,001 people	5	29%

The weapon of choice in 94% of the homicides was a firearm, primarily handguns (Table 38). In all twenty-two people died as a result of the seventeen cases. Seventeen were the primary victims, five were secondary victims who were there at the time of the death event; three of the five were the perpetrators children.

Table 38. Mechanism/ Cause of Victim's Death

Firearm	16	94%
Shotgun/Rifle	*3*	*18%*
Handgun	*13*	*77%*
Strangulation	1	6%

Two of the victims had a positive toxicology report for alcohol, and six perpetrators had a positive toxicology report. In all drugs and/or alcohol use by the victim, perpetrator or both was associated with the death event in six cases. In 59% of the homicide-suicides there

were witnesses to the death event; in 18% of the cases a child was a witness to the death event.

Twenty-four percent (4) of victims had filed a Victim Protection Order (VPO) against their perpetrator. In one case, a judge ordered mutual protective orders when the victim filed for a VPO. Of the VPOs filed, 75% had been served prior to the death event, and half were active at the time of death. In only one case were the VPOs known to have been violated (See Table 39).

Table 39. Of the filed Victim Protection Orders

	VPO had been served		VPO was active		VPO had been violated	
No	1	25%	2	50%	1	25%
Yes	3	75%	2	50%	1	25%
Unknown					2	50%

In 41% of the cases, at least one other person or entity had knowledge of the existence of domestic violence/sexual assault between the perpetrator and victim (See Table 40). Family members knew of the domestic violence/sexual assault in 71% of the cases, followed by law enforcement and family court/VPO in 57% of the cases. In addition four victims reported to others that the perpetrator was stalking them prior to the death event.

Table 40. Who knew?*

No evidence of DV/SA	6	35%
Unknown	4	24%
Law Enforcement	4	57%
Family Court/VPO	4	57%
Family	5	71%
Friends	2	29%
Co-worker/Employer	1	14%

*In 7 cases at least one entity/person knew of DV/SA between victim and perpetrator. The percentages are figured based on the number of cases in which someone else knew.

2002 DVFRB Systemic Concerns

From these findings the Board developed areas of concern and recommendations that could alleviate the identified issues. The following areas were highlighted by Board members:

- For the most part, when victims and perpetrators accessed services they performed in appropriate ways. However, there were a few areas noted by the reviews that could improve the delivery and/or availability of services.

- Some providers were well equipped to handle and assist those they are meant to serve in regards to domestic violence. Others appeared ill equipped to offer assistance, while others were ignorant of the issues, concerns and the possible lethality of the situation they were facing.

- Victims and perpetrators had repeated contacts with all systems, often with several providers. In some cases, one or two system providers were aware of ongoing domestic violence. In most of the cases, many, if not all, of the providers were unaware of the violence. Even when recognized, screening performed by service providers did not attempt to assess the lethality of the situation.

- Several cases highlighted the fact that Oklahoma's criminal justice computer data systems do not interface. There are many fine data systems currently in use by law enforcement, prosecution, the courts and corrections, but without access to the other systems, the cracks in the current system allow perpetrators to "slip through" with little or no follow-up. Accessing the various systems separately costs time and very scarce resources for those attempting to span the gaps.

- Joint custody puts victims in danger by allowing the abuser "legal" access to the victim and children. Children more easily become pawns or a control mechanism over the victim.

- Violation of Victim Protection Orders appeared to carry little consequence within the criminal justice system beyond initial law enforcement response. This cavalier attitude erodes the faith of the victim and encourages aggression by the abuser.

- *To fully address systems having contact with victims and perpetrators of domestic violence, additional voices need to be "at the table" during the death review process.*

2002 DVFRB System Recommendations

Courts

1. Establish a legal presumption against joint legal custody in cases involving domestic violence.
2. Mandate continuing domestic violence training for all judges*
3. Add Judicial representative to the Domestic Violence Fatality Review Board*

Department of Corrections

1. Probation and parole officers should document and report incidents of domestic violence
2. Screen parolees and probationers for lethality at intake into system and prior to release for referral to services

Department of Human Services

1. Add Department of Human Services representative to the Domestic Violence Fatality Review Board*

Department of Mental Health and Substance Abuse Services (DMHSAS)

1. Review, revise and strengthen minimum standards for Batterers Treatment
2. Train providers and advocates to refer children and adult witnesses to domestic violence related deaths to appropriate trauma counseling
3. Strengthen integrative services – screening for domestic violence, mental health, and substance abuse should occur at all entry points into the system

District Attorneys

1. Training on domestic violence and lethality, evidence based prosecution, and "no tolerance" policies
2. Support DMHSAS efforts that DUI offenders be tested for propensity to violence in cases of court-ordered counseling
3. Intervene in every Victim Protection Order violation, a minimum of batterers counseling/treatment should be sought

Domestic Violence Advocates

1. Seek to expand services – geographic and variety
2. Introduce and educate advocacy providers in the Domestic Violence Emergency Response Team model
3. Make services culturally appropriate to the community

Health Care

1. Mandate domestic violence recognition and reporting training for all emergency technicians and health care professionals*
2. Legislate minimal domestic violence and lethality screen (as necessary) at each medical encounter and include in medical record*

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* Legislative Action Required

3. Encourage the creation of protocols and documentation tools by professional associations such as the Oklahoma Nurses Association, Oklahoma Osteopathic Association, Oklahoma State Medical Association, Licensed Professional Counselors, Oklahoma Psychological Association, Oklahoma Association of Social Workers, etc.

Law Enforcement

1. Mandate continuing education in Domestic Violence for all Council on Law Enforcement Education and Training (CLEET) certified officers. Training should include at a minimum the importance of reporting domestic violence incidents and evidence based investigation of domestic violence*

Overall Systems

1. Intensify and Coordinate Domestic Violence training within Oklahoma
    a. Broaden the composition of Child Abuse Training Coordination Council to encompass all providers of family violence training (i.e., Attorney General's Office, Oklahoma Regional Community Policing Institute)*
    b. Conduct a needs assessment for Oklahoma
2. Implement interfaced statewide criminal justice data system*
3. Develop "Promising Practices" tools
    a. Develop standards of care and services for child victims and witnesses
    b. Adopt appropriate, validated lethality assessments across disciplines

Board Process Recommendations

Recognizing that the effort to prevent domestic violence homicides must be a coordinated, holistic approach, the Board realizes that it must set goals and recommend change for itself as well as doling out recommendations to others. To that effect, the Board discussed and recommended Board goals for the coming year. The following are the finalized goals of the Domestic Violence Fatality Review Board for 2003.

1. Evaluate current review process
2. Increase use of consultants during case review
3. Integrate members from the Department of Human Services and the Judiciary onto Board
4. Conduct ongoing Board training
5. Increase use of Department of Human Services and medical records

In reviewing the past year, the Board found themselves with much information about the perpetrators, and relatively little about the victims. This dilemma brought forth several suggestions as to how to obtain equitable information about victims. One proposal involved having law enforcement gather the data using a standardized form with the variables of interest. Such forms are already in use in other states, and could be modified for use by Oklahoma. The Board felt that such a form must be valid, proven effective in our state and it should not be an onerous burden to line officers. To make sure the recommended form fit these parameters, the

* Legislative Action Required

Chief of the Broken Arrow Police Department and the District Attorney from District 6 with the Caddo/Grady County District Attorney's Native American Unit offered to use the form in a one-year pilot test. The outcome of the pilot will be reported in the Board's 2003 Annual Report.

Conclusion

Domestic violence is a major criminal justice, public health and social problem in Oklahoma. Every year a substantial number of homicides in the state occur as a result of domestic violence. These tragedies should serve as a wake-up call that not only is domestic violence a reality in the state, but it is a real threat to the life and safety of our women, children and men. Very few domestic violence homicides are a one-time spontaneous event. Most often they are a culmination of many prior events that escalated in severity along the way, ultimately ending in the death of one or more persons. The most frustrating part of that picture is that, so often, many people know. Many people know that there was violence in the relationship—they saw the terror in the eyes of their family member, they knew the perpetrator would not let them talk to their friend, they knew the bruises did not match their client's explanation—yet they felt unable, unqualified, or just did not know what to do to help. When the ultimate tragedy occurs, they begin to regret not doing more to get that person to safety and avoiding the death of a friend, family member or client.

The Oklahoma Domestic Violence Fatality Review Board believes that through improved system response, much of this regret can be avoided. If all the systems coming into contact with an individual in a domestic violence situation are prepared and informed about the dynamics of domestic violence, and have policies and procedures in place to support their assistance to that individual, the number of cases that result in homicide can be greatly reduced. The recommendations included in this report are but the first step in a long process of getting all systems on the same page.

The Board realizes that there are many areas that need further investigation to promote the understanding of domestic violence and appropriate responses. The following are a few suggestions for further investigation borne of the reviews this past year.

- Conduct studies of survivors who left their abusive relationship, identify accessed services and support networks, risk factors, and systemic needs
- Conduct longitudinal studies to identify the effects of domestic violence on children who witness the violence, in particular those who witness homicides and/or suicides, appropriate responses and services
- Identify ways to measure alcohol and substance use by all persons at scenes of domestic violence
- Investigate the efficacy of victim protection orders
- Examine the efficacy of victim advocate services
- Assess and implement early intervention strategies for both victims and perpetrators
- Study the efficacy of Batterer Intervention Services
- Explore the efficacy of Domestic Violence courts as an intervention strategy
- Examine the impact of community acceptance, with an eye to cultural differences

- Investigate the intersection of domestic violence and firearms
- Assess the intersection of domestic violence and other criminal offenses
- Examine the intersection of domestic violence and drugs and alcohol
- Determine methods to see how many domestic violence homicides were possibly prevented and means of occurrence

The Domestic Violence Fatality Review Board has been a valuable schematic for a multi-disciplinary group of service providers to identify some of the systemic challenges and barriers these victims may have encountered and make recommendations for improving services. While the elimination of domestic violence is certainly the ultimate goal, Board members acknowledge that this begins with specific and manageable strategies for change. However, this work has just begun, and in coming years as the database likely grows, so will the ability to frame recommendations with larger and more precise impact and improvement in services for victims.