

Two killed  
sheriff hurt  
in shootout  
Police: no firm leads in murder  
Adoration,  
death: What  
happened?

Community is dealing with double tragedy  
Victim had been abused before  
Children of murder victim tell police of past episodes; father still at large



Neighbors say  
slain father tried  
dispatchers Sunday night, telling them she shot her father.  
Police have not released the names of the girls.

Police searching for man accused

# Domestic Violence Homicide

Anad  
held f  
of cit

man  
street

City police still investigating couple's death



Murder on Man  
Murder suspect caught  
ted in beating death of wife arrested in Bromide

An Unusual Life...and A Most Unusual Death



Couple's deaths stun community

Suspect Released on Bond

Guymon Man Charged with Murder

Murder Charges Filed In Early Morning Shooting

Manslaughter Charges Filed



Executive Summary

A Multi-Disciplinary Analysis by the Oklahoma Domestic Violence Fatality Review Board

2003

Marrned couple  
found dead  
by daughter



Woman stabbed  
son claims wife  
murdered by band  
of devil worshippers  
Suspect doesn't remember beating

# EXECUTIVE SUMMARY

December 2003

## MISSED OPPORTUNITIES

**P**olice confined a woman on an Emergency Order of Detention after she put a gun to her boyfriend's head and pulled the trigger (he was not hurt). The woman walked away from the mental health facility and a day later killed her boyfriend. The facility's staff did not call police to let them know she left without permission.

**A** man who killed his estranged wife had acquired a rifle 11 days prior to the murder/suicide. On his ATF screening statement, the perpetrator responded "No" to the question "have you been convicted in any court of a misdemeanor crime of domestic violence?" The man had a 1996 conviction for domestic assault and battery, which should have disqualified him from purchasing a firearm.

**A** man who was on probation for violating a Protective Order (PO) was being held in the county jail for another violation. He continued the violation by calling his

victim -- from the jail's telephone -- and making death threats. When the victim reported the calls to city police, officers told her to call the sheriff's office and report the calls herself. Two days after being released from jail, the man killed the woman.

**A** man who kidnapped and raped his ex-girlfriend began threatening suicide. His family took him to a hospital five days later for in-patient mental health treatment. Two doctors and a counselor told the man's family his condition was not bad enough for him to be hospitalized. They referred the man to a private counselor. He killed his girlfriend and himself 12 days later.

**A** court issued an arrest warrant for a man accused of violating a PO filed by his estranged wife. The sheriff did not serve the warrant. Local police, despite responding to DV calls at the woman's home, were not aware of the

arrest warrant. The man killed his wife and himself 21 days after the warrant was issued.

**A** man was arrested for violating the PO his estranged wife had filed against him. He posted bail. Hours later he killed his estranged-wife's boss and shot her.

**T**he Chief of Police knew about death threats made against the victim by her estranged husband. The chief failed to serve an emergency ex-parte order because he had heard the couple had reached a property settlement. The man killed his estranged wife and himself.

**A** woman made several reports to police and her boyfriend's parole officer regarding her boyfriend's physical abuse. The police gave the reports to the DA. No charges were filed, and parole was not revoked. The perpetrator killed the victim less than a month later.

### Of the 113 Reviewed Cases

- In 57% of the cases there was a documented history of domestic violence between the victim and perpetrator.
- Firearms were used in 59% of the homicides.
- A current or former intimate partner was the perpetrator in 61% of the cases

## THE PROBLEM

Domestic violence is an issue with far reaching medical, emotional, personal, economic, professional and legal consequences for many people. According to the National Center for Injury Prevention and Control, close to 5.3 million intimate partner victimizations occur each year among women ages 18 and older in the United States — some 1,300 women

- In 2002, spouses, family members, boyfriends/girlfriends, and/or member of romantic triangle committed 2,450 (17%) murders in the United States.<sup>1,2</sup>
- In Oklahoma, 174 (32%) murders fit the definition of domestic violence by statute from 1998-2000.
- In a surveillance from 1981-1998, 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.<sup>3</sup>
- In 2001, Oklahoma ranked 10<sup>th</sup> in the nation for number of females killed by males in single victim, single offender incidents. This is up from 19<sup>th</sup> in 2000.<sup>4</sup>

lose their lives as a result of this violence. Based on these numbers, intimate partner violence costs the United States more than an estimated \$5.8 billion dollars annually — close to \$4.1 billion for medical and mental health care, \$0.9 billion in lost productivity, and \$0.9 billion in homicide lost earnings. These numbers do not even begin to account for the cost to the criminal justice system — law enforcement, prosecution, courts, and the penal system.

In a time when most agencies and service providers are facing budget cuts it is important that a systematic approach be applied in determining the causes and resolutions of domestic violence. With costs that can number in the billions annually when all things are considered, the use of a multidisciplinary systems approach assists agencies and service providers involved with domestic violence to determine how to best utilize their limited resources to serve those in need. Throughout this report the Oklahoma Domestic Violence Fatality Review Board (DVFRB) has focused on systems issues which, if improved, could save the lives of victims.

## OKLAHOMA DOMESTIC VIOLENCE FATALITY REVIEW BOARD

This report summarizes the work of the Oklahoma DVFRB created by the Oklahoma State Legislature in 2001. The multi-disciplinary review team has met monthly since September 2001 to review deaths of Oklahomans due to domestic violence. Board members represent the disciplines of the multiple stakeholders involved in resolving domestic violence homicides. As such, the members are sensitive to the concerns and purposes of the organizations and fields of expertise they represent. Inclusion of this variety of professionals ensures 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.

*“ . . . 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.”*

DVFRB members represent the Chief Medical Examiner, the Department of Mental Health and Substance Abuse Services, the State Commissioner of Health, the Director of the Criminal Justice Resource Center, the Chief of Injury Prevention of the State Department of Health, the Oklahoma Council on Violence Prevention, the Director of the Oklahoma State Bureau of Investigation, the Oklahoma Sheriff's Association, the Oklahoma Association of Chiefs of Police, the Oklahoma Bar Association, the District Attorneys Council, the Oklahoma State Medical Association, the Oklahoma Osteopathic Association, the Oklahoma Nurses Association and two individuals from the Oklahoma Coalition Against Domestic Violence and Sexual Assault, one of whom shall be a survivor of domestic violence. Additionally, the Board is staffed by research professionals from the Oklahoma Criminal Justice Resource Center.

1 Federal Bureau of Investigation. (2003). *Crime in the United States 2002: Uniform Crime Reports*. Washington, DC: U.S. Government Printing Office.

2 Figures are based on 14,054 murder victims for whom Supplementary Homicide Reports were received.

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

4 Violence Policy Center. (2003). *When Men Murder Women: An analysis of 2001 data*. Washington, DC: Author.

## KEY FINDINGS

During the past year the DVFRB focused on the 159 cases identified from 1998 and 1999. Of these, it reviewed 38 cases, adding to the body of work initiated by the Pilot Project. To date the DVFRB has reviewed a total of 113 cases.

While there were many cases in which victims accessed services and were known to service providers, there were just as many cases in which the systems designed to protect victims did not work optimally. Review discussions were often emotional for DVFRB members. All of the deaths were tragic; many were horrific. Each review pinpointed areas of need, as well as areas of success. This report

presents the findings of the case reviews. It concludes with systemic recommendations for change. DVFRB members are adamant that the victims' lives and deaths should not be in vain. The review of each death and those events leading to it suggests recommendations and strategies to bring changes in our legal, law enforcement, health care and service systems. Ultimately, the DVFRB believes adoption of these recommendations will save lives.

### Of the 113 reviewed cases:

- Average age of victims was 37 years old and 38 years of age for perpetrators
- 79% of the victims were White, 16% were Black and 5% were American Indian.
- Nearly 4% of victims were of Hispanic or Latino origin
- In 56% of the cases, the perpetrator and victim were cohabitating
- 9% of victims told someone the perpetrator was stalking them prior to their death
- 67% of the homicides occurred at the victim's residence
  - \* 30% occurred in the bedroom
  - \* 27% occurred in the living room
- Charges were filed in 72% of the cases
  - \* 89% were convicted
- 96% of those convicted were sentenced to prison
  - \* The average sentence was 21.11 years (not including life or life without parole)
  - \* 14 received life in prison
  - \* 19 received life without parole

## SYSTEMIC CONCERNS AND RECOMMENDATIONS

### Concern:

All providers should document any type of domestic violence their client may be experiencing or inflicting.

*In at least 9 cases, family, friends, and/or neighbors report alerting law enforcement to prior incidents of violence between the victim and perpetrator. No incident reports or follow-up documentation of these responses were found.*

### Recommendation:

- **Health Care:** Health care providers should seek domestic violence screening, assessment, and recognition training in all hospitals (in & out patient), long term healthcare & community care providers, Emergency Rooms, Primary Care, Obstetrician/Gynecologists, Health Departments, Planned Parenthood, etc. [Partner with Oklahoma State Department of Health] to improve screening, assessment, identification & documentation of domestic violence risk factors.
- **Law Enforcement:** Document and file incident reports on all domestic violence contacts – regardless if the original call designation specified the event to be a domestic situation.

## SYSTEMIC CONCERNS AND RECOMMENDATIONS

### Concern:

Screening performed by service providers should assess the lethality of the situation when there is on-going domestic violence.

### Recommendation:

- *Courts:* Courts should perform lethality assessment before setting bail on domestic violence offenses.
- *Department of Mental Health and Substance Abuse Services:* Review Emergency Order of Detention assessments, strengthen lethality risk by utilizing outside sources [DMHSAS & private facilities].
- *Law Enforcement:* Law Enforcement should perform Danger/Lethality Assessments on all domestic violence calls – with particular attention to weapon accessibility & presence.

*Law enforcement responded to prior domestic violence incidents in the month preceding death in at least 15 cases. In 11 of those cases, the homicide was committed with a firearm.*

### Concern:

Providers across the board should perform domestic violence screening.

### Recommendation:

- *Department of Human Services:* Improve capacity of DHS workers to assess danger to children by including domestic violence screening and response.
- *Department of Mental Health & Substance Abuse Services:* Standardize assessments in mental health to include screening for domestic violence and appropriate referral/care [DMHSAS & work with Health Care Authority-Licensed Behavioral Health Specialists].
- *District Attorneys:* Support DMHSAS efforts that DUI offenders be tested for propensity to violence in cases of court-ordered counseling.
- *Health Care:* Health care providers should provide domestic violence screening, lethality assessment and identification for specific intervention to reduce risk (or vulnerability) and increase safety, especially of women, children, people with disabilities and elders (i.e. referral resources, safety planning).

*14% of victims had contact with the Department of Mental Health & Substance Abuse Services prior to death. 50% of victims had contact with the Department of Human Services in the year prior to death.*



## SYSTEMIC CONCERNS AND RECOMMENDATIONS

### Concern:

Domestic violence offenses appear to carry little consequence within the criminal justice system beyond initial law enforcement response.

### Recommendation:

- *District Attorneys:* Make second and subsequent violation of PO a felony.\*
- *District Attorneys:* Increase penalty range for Domestic Assault & Battery – After Former Felony Conviction.\*

*Protective Orders were utilized in 19% of the reviewed cases. Over half of those POs were violated at least once prior to the death event.*

### Concern:

The breadth of services and service providers should be expanded. Those providing services should strive to continually educate themselves in order to ensure the safety of their clients.

*There were witnesses in 58% of the cases.*

- *Adults witnessed the homicide in 45% of the cases.*
- *Children were present for 36% of the slayings.*
- *16% were eyewitnesses to the event.*

### Recommendation:

- *Department of Human Services:* Identify and make referrals to services available for victims of domestic violence and their children.
- *Department of Mental Health & Substance Abuse Services:*
  - Continue to strengthen integrative services – screening for domestic violence, mental health, and substance abuse should occur at all entry points into the system.
  - Continue to review, revise and strengthen minimum standards for Batterers Treatment.
- *Domestic Violence Advocates:*
  - Seek to expand services – geographic and variety.
  - Develop targeted outreach programs to reach those victims who have no contacts with the system, especially in rural areas.
- *Legal:* Training/Education on representing victims of violence: Target all attorneys who work in divorce/family law through law school and Continuing Legal Education Units.
- *All Systems:*
  - Develop Family Justice Centers for comprehensive service and support for victims of domestic violence. Centers should be designed to improve victims' access to critical services by housing them in one location.
  - Increase cultural competency.
- Funding should be prioritized for domestic violence services in all areas — support for Domestic Violence Emergency Response Teams (DVERT), prosecution of domestic violence offenses including protective order violations, etc.

## SYSTEMIC CONCERNS AND RECOMMENDATIONS

### Concern:

Providers should implement policies that ensure the increased safety of the victim.

*In 57% of the cases, someone else knew of the ongoing domestic violence prior to the homicide.*

- 59% Family
- 50% Friends
- 44% Law Enforcement

### Recommendation:

- *Courts:* Stipulate that as a condition of bond, defendants make no contact with the victim.
- *Courts:* Increase awareness of the role of the judiciary in preventing domestic violence, specifically in the areas of victim safety and offender accountability.
- *District Attorneys:* Provide *Evidence Based Prosecution* and *Domestic Violence 101* Training to all District Attorneys and Assistant District Attorneys that prosecute domestic violence.
- *Domestic Violence Advocates:* Public information campaign, i.e., How Do I Help?

## CONCLUSION

Domestic violence is a continuing problem in Oklahoma, and one with extreme costs to citizens. It is important to use a multidisciplinary systems approach to resolve issues surrounding these life-threatening situations. This report is essential to understanding the complexity and severity of intimate partner violence in our society. The use of real life, empirical data illustrates the need for all systems to band together to protect the lives of Oklahomans.

If all the systems that may be contacted by an individual in a domestic violence situation are (1) prepared and informed about the dynamics of domestic violence, and (2) have policies and procedures in place to support their assistance to that individual, a significant reduction in the number of cases that result

in homicide can be realized.

The DVFRB has come a long way since inception. It is the sincere hope that the hard work done in 2003 will aid in the prevention of domestic violence homicides in Oklahoma. Recommendations for this year's reports were more specific than last year's due to the growth of the database, and the maturation of the DVFRB itself. Framed recommendations will become more precise in the following years for the same reasons. The DVFRB expresses gratitude to those who have already implemented change, and issues a challenge to systems to use this data and these recommendations to aid future and current victims of domestic violence and save lives.

**DOMESTIC VIOLENCE FATALITY REVIEW BOARD**

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

**Safeline – 1-800-522-7233**

If you need general information about Domestic Violence, please call:

**Oklahoma Coalition Against Domestic Violence  
and Sexual Assault – (405) 848-1815**

If you need more information about the Oklahoma Domestic Violence Fatality Review Board, please call:

**Oklahoma Criminal Justice Resource Center –  
(405) 524-5900**

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

*This Executive Summary was prepared by the Oklahoma Criminal Justice Resource Center, Statistical Analysis Center  
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