Domestic Violence: Structure, Impact and Collaboration

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United States Facts

- Over 4.8 million women are affected by abuse*
- Over 2.9 million men are affected by abuse*
- 14% of US children either witness or directly experience abuse*
- 1 in 25 of the elderly population experience some type of abuse*

*Data obtained from the Center for Disease Control.
State DV Facts

- Although 2013 FDLE Uniform Crime Report showed that crime rate is the lowest in 43 years, domestic violence only decreased by < 1%.

- According to FDLE, stalking increased 25.9% in 2013.

- Oct. 1st, 2012, the Florida’s stalking law went into affect and stalking increased 130% in 2012
Miami-Dade County Facts

According to the Medical Examiner’s office, in 2016, there were a total of:
- 231 Homicides
- 244 Suicides

According to data collected by the Fatality Review Team, in 2016, there were a total of:
- 53 DV-related homicides (16%)
- 15 DV-related suicides (6%)

According to FDLE, Stalking and Aggravated Stalking increased by 6% for in Miami-Dade County.

Miami-Dade County is ranked 1st in the state in domestic violence-related incidents.

Cost to employers $152,666,073 annually in lost productivity, absenteeism, medical and mental health cost.
Legal Definitions
Florida Statute 741.28: Domestic Violence

“Domestic violence” means any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another family or household member.
The Sociological Definition
Domestic abuse is a pattern of coercive behavior, including acts or threatened acts, that is used by a perpetrator to gain power and control over a current or former spouse, family member, intimate partner, or person with whom the perpetrator shares a child in common.

Domestic abuse may include, but is not limited to, physical violence, injury, or intimidation, sexual violence or abuse, emotional and/or psychological intimidation, verbal abuse, threats, or harassment, stalking, or economic control.
Defining Domestic Abuse: Issues

- Involves the use of
  - Violence
  - Coercion
  - Threats
  - Intimidation

- Purpose: Establish/Maintain one person’s *power & control* over another
- Is a *learned* behavior in which the abuser *chooses* to engage
- Occurs in all social economic, religious, ethnic, age & education groups, as well as both homosexual and heterosexual relationships
Defining Domestic Abuse: Issues
Continuum of Abuse

HEALTHY  UNHEALTHY  ABUSIVE
Understanding the Abuser

- Domestic abuse is **NOT** caused by substance abuse or mental illness.

- Theses might co-occur, but are not the root cause.

- Anger is not a root cause but is present.

- Domestic abuse is about a **flawed beliefs system**, where the perpetrator believes they have the right to control and abuse their partner- sense of entitlement.
Trapping the Survivor
Trapping the Survivor

- Abusers use tactics on the Power & Control Wheel to literally trap survivors in the relationship.

- Survivors might hear things like:
  - You are to blame
  - I will find you
  - I will kill you/the children/pet or commit suicide
  - I will change & it will never happen again

- Survivors might experience:
  - Seeing abuser handling weapons
  - Having keys to car taken away
  - Having phone calls screened/tracking via devices
  - No access to money
The Life Where All Everyone Sees is the Tip of the Iceberg...
The Life a Survivor is Experiencing

- Depression
- Low Productivity
- Exhaustion
- Kids/Pets
- Trauma
- Fear
- Abuser
- Sleep deprivation
- His Family
- Child Support
- DCF
- Divorce
- Prosecution of Abuser
- Physical Pain
- Immigration
- Work
- Bruises
- Bills, Rent on One Income
- Her Family
- Moving
- Personal Life Issues
Early Warning Signs of Abuse

- Abuser builds survivor up so they believe they are in control
- “Knight in Shining Armor”
- Fast, intense relationships
- Isolation from family and friends
- Control of who they are with or where they go
- Abuser belittles and puts survivor down
Understanding Why Survivors Stay:

- Fear
- Children
- Faith/Religion
- Isolation
- Finances
- Homelessness
- Love & belief in change
- Staying is often “safer” than leaving
Why Survivors Stay Cont’d.

- Leaving is not just one step
  - It is a process that may take longer for some than others

- Many barriers need to be overcome before a survivor can leave
  - Makes it easier: help a survivor find an advocate who can provide a safety plan & resources:
    - Housing
    - Child care
    - Financial resources
    - Legal protection
    - A strong support system
Five Types of Domestic Violence Injunctions

- Domestic Violence with and without children
  - Petitioner and respondent must be family or household members. § 741.30(1)(e).
  - “Family or household member” means spouses, former spouses, persons related by blood or marriage, persons who are presently living together as if a family or who have lived together in the past as if a family and persons who are parents of a child together regardless of whether or not they have been married or lived together. § 741.28(3).

- Dating Violence
  - Requires a dating relationship existing in the past 6 months between the parties, which had an expectation of affection or sexual involvement, and was of a continuous nature. The term does not include violence in a casual relationship or violence between individuals who have only engaged in ordinary fraternization in a business or social context. § 784.046(1)(d)
Five Types of Domestic Violence
Injunctions Cont’d

- **Sexual Violence**
  - Any one incident of: sexual battery, as defined in chapter 794; lewd or lascivious act, as defined in chapter 800, committed on or in the presence of a person younger than 16; luring or enticing a child, as described in chapter 787; sexual performance by a child, as described in chapter 827; or any other forcible felony where a sexual act is committed or attempted. § 784.046(1).

- **Repeat Violence**
  - Two incidents of violence or stalking committed by the respondent, one of the which must have been within 6 months of the filing of the petition, which are directed against petitioner or petitioner’s immediate family member. § 784.046(1)

- **Stalking**
  - Willfully, maliciously, and repeatedly following, harassing, or cyberstalking another person. Two incidents are required. Stalking includes cyberstalking. §§ 784.048(2) and 784.485(1)
Assessing Lethality

- Top 4 things that indicate that an abuser is more likely to kill:
  1. Recent Separation
  2. Suicidal / Depression
  3. History of domestic abuse with an increased escalation of violence
  4. Stalking

- Lethality may **INCREASE** when a survivor is **GAINING ANY** independence or pulling away from their abuser.
Identifying DV Risk Factors

- Prior Death Threat
- Self-reporting incidents of DV
- Multiple police incident reports/call-outs
  - Lethality Assessment
- Recent separation
  - Still residing together while in a relationship with someone other than Perpetrator
  - Initiation of domestic violence injunction and/or dissolution of marriage
- Prior DV-history
  - Increased lethality = strangulation, Battery while Pregnant
- Escalation of violence
- Stalking
  - Cyber, GPS, personal
- Economic Loss
Micro-dynamics of Risk Factors

- Clustering of multiple risk factors exponentially increases lethality

- Combination of socio-economic factors
  - Legal status, employment status, lack of family support

- Intergenerational abuse/learned behavior

- Homicide/Suicide and Familicide
Preventable or not preventable?

...that is the question.
Fatality Review Team

The primary function of the local review committees is to conduct individual case reviews of deaths, generate information, make recommendations, and implement improvements at the local level.

DVFRT & CADR brings together professionals from diverse agencies and backgrounds in an effort to review domestic violence-related fatalities and child death cases with a “lens of preventive accountability”. Through multi-disciplinary review, we are able to more fully understand the dynamics of domestic violence-related deaths, develop inter-system policies and protocols geared towards prevention (creating a “seamless system”), and thereby reduce future fatalities.

Goals:

1. To reduce domestic violence related death and child death in general and lethal violence in particular
2. To review facts and circumstances of domestic violence and child death
3. To establish a process of accountability which allow for policy changes, training, and supervision
4. Improve interagency communication and systemic improvements
5. Analyze, records, and report collected data used to produce annual reports
6. Educate policy makers, funding agencies, and the public about domestic violence and child fatalities
Legislation

- In 1998, The Miami-Dade County Domestic Violence Fatality Review Team (DVFRT) was created as one of four jurisdictions chosen by the Florida Governor’s Task Force on Domestic Violence to lead the way in a landmark initiative, “Implementing Fatality Review Teams in Florida.” See F.S. §741.316.

- In 2001, the DVFRT became state certified as the local entity for reviewing all cases reported to the DCF where a child death occurred due to abuse and/or neglect, therefore forming the Child Abuse Death Review Team (CADR). See F.S. §383.402(3).

- In 2002, Miami-Dade County was the first county to take the initiative to convert the local child death review process from one that was internal within the Department of Children & Families (DCF), to one that is multi-disciplinary, community-wide, as per Florida and national child death review legislation. By merging both the adult and child death review processes under the same umbrella, and becoming the state certified entity in Miami-Dade County to perform this function. See F.S. §383.402 and §383.412.

- This undertaking has also served as a means of recognizing that family violence, including child maltreatment, must be viewed holistically.
Effective 2006, the CADR was charged with reviewing all “verified” deaths due to abuse or neglect for Monroe County.

Effective July 1, 2014, the CADR Team was charged with reviewing all deaths that occurred Miami-Dade and Monroe County, where the DCF Abuse Hotline received a report. The Team is mandated to review all child death cases that alleges medical neglect, physical neglect/abuse, sexual neglect/abuse, whether or not the allegation was substantiated, including natural causes and unclassified deaths.

All information and records acquired are not subject to discovery or introduction into evidence in any civil or criminal action or administrative or disciplinary proceeding by any department or employing agency. See F.S. §741.316(4).
Domestic Violence Fatality Review Team (DVFRT) & Child Abuse Death Review (CADR) Team Members

- Medical Examiner’s Office
- Law Enforcement
- Department of Children & Families
- Our Kids
- Administrative Office of the Courts
- Guardian Ad Litem
- School District Members
- State Attorney’s Office
- Child Protection Team

- Domestic Violence Community Partners
- Mental Health Professionals
- Healthy Start
- Domestic Violence Shelters
- Victim Advocates
- Department of Health
- Medical Doctors/Nurses
- Private Attorneys
Role of Team Members

- Maintain confidentiality
- What recommendations can be made to prevent this death from happening in the future
- Clear understanding of their own agency role
- Respect other team member’s professional opinions
- Contribute information from their respective agency records
- Explain the legal responsibilities of their agency as it pertains to the case
- Contributes by suggesting agency recommendations that will lead to a reduction in domestic violence and child fatalities.
- Identify what polices and procedures that need improvement
Benefits of Fatality Review Teams

- Diverse community partners are able to identify gaps in the our community response to DV
- “no blame” philosophy inspires increased agency collaboration
- Missed opportunities for intervention
- Help identify agency/program improvements based on needs
- Ability to track local mortality trends
  - Accurate data collection
- Community Campaigns
  - Domestic Violence
  - Child Abuse/Neglect
  - Safe Sleep Initiatives
  - Drowning Prevention
- Judicial trainings
- Participation in other coalitions
DFVRT Findings & Recommendations

- Death threats should have been taken seriously by family and it was recommended that educational awareness of death threats should be a training topic to focus throughout the community.
- Stalking was present. Therefore it is recommended that educational awareness of stalking as a predominant lethality indicator is needed.
- The Review Team determined that it is beneficial for employers to provide on-going continual training in domestic violence and workplace safety, including training on lethality indicator assessment.
- The Review Team engaged in a discussion about the use of coercive control including intimidation, stalking, and harassment, acknowledging the fact that it was used to hurt and manipulate the child’s mother.
- The Review Team felt there is a need for laws preventing private investigators from rendering services to an individual who is a party to a domestic violence injunction or criminal stay-away order.
- The review revealed that the pending Dissolution of Marriage proceeding initiated by Decedent was identified as the primary motivating lethality indicator for this DV-related homicide. In this specific case, Perpetrator’s strong Muslim religious and cultural beliefs which denounces a wife from divorcing her spouse, played a significant factor. Furthermore, the extremity of this lethality indicator was the impetus for Perpetrator to go directly to Decedent’s family law attorney’s office immediately following the fatal incident, with the apparent intent to shoot and kill Decedent’s attorney. Therefore, the Review Team believed that the effects of the divorce being sought by Decedent were aggravating factors that escalated the violence inflicted by Perpetrator.
- The Review revealed that the Decedent’s mother made no reference to Decedent on her Petition for injunction for Protection Against Domestic Violence. The Review Team recommends that the State of Florida revise the Injunction for Protection petition to include an area to list children not common to both parties, yet who reside in the residence. The Review Team discussed the importance of disclosing all children who reside in the residence to the judicial system.
Implementation

- As a result of the fatal incident, DCF conducted an internal investigation concerning the lack of services in this case. Approximately two years after the fatal incident, with the recommendations of the Team, the lead DCF worker that was assigned to this case was charged with six counts of Official Misconduct, pled guilty and was sentenced to Probation.

- In 2017, the Eleventh Judicial Circuit drafted revisions that are in process of being approved by the Florida Supreme Court for use in our circuit. The revisions include adding children not common to both parties (any that reside in the home), addition of “other” category in gender field, increased space to write more detailed narrative under allegations, more detailed information regarding mental health history, question including if Perpetrator was also in the military in a foreign country, and temporary possession of pets.

- As a result of this fatal incident, in combination with other DV-related deaths, the municipality in which the death took place launched a campaign aimed to preventing domestic violence in the community. The campaign’s focus is to encourage victims to report all incidents of DV and child abuse to law enforcement agencies, without fear. The Team felt this should be a long-term goal, and should be replicated countywide.

- As a result of the fatal incident, a public awareness campaign was created by the victim advocates in the local law enforcement municipality. Educational awareness and presentations where distributed throughout schools and at PTSA meetings, which is a long-term goal.

- Records revealed that the Victim’s Compensation Program provided payment for funeral and burial expenses.
The Review Team recognized the importance of parent education and on-going media campaigns, such as public service announcements and awareness billboards, to educate the public on the risks of inadequate child supervision.

Records indicated that Decedent was not placed in a crib to sleep and that Decedent’s pac-and-play contained numerous objects, revealing a need for public awareness regarding safe sleeping arrangements for infants.

The review team engaged in a thorough discussion relating to the prevalence of fetus and infant drug-related deaths. The Team agrees that educational awareness is needed in our community to alert parents as to the risk of drug use during pregnancy and the correlation between drug use and premature birth, which is strongly associated with infant mortality.

Although Decedent’s manner of death was classified as Natural, the Review Team recommends that all Miami-Dade County park employees, including all city park employees throughout the county, be given mandatory CPR training annually, beginning with those parks where child camps are held.

The Review Team recommends that the Florida Department of Agriculture and Consumer Services in conjunction with the Florida Fish and Wildlife Commission install signage in common riding areas, warning OHV riders of the potential dangers associated with mudding. These signs should specify the Florida Statute that prohibits riding OHV on public lands and all fees associated with the violation of this statute.
Records indicated that presently, there are not laws or ordinances mandating barriers or signage in residential communities that have bodies of water. The Review revealed that there were no barriers or signage installed near the body of water, adjacent to Decedent’s residence. The Team recommends that visible signs be placed in all communities where bodies of water are near or adjacent to homes, stating the potential risks of leaving children unattended.

The Review Team engaged in a lengthy discussion regarding Decedent’s complex mental health history, suicidal warning signs, and fast decompensation. The Review Team recommends that in all minor patients who have a mental health history, be appointed a case manager and/or mental health advocate, to assist a patient’s family to navigate the mental health system. The Team suggests that a system needs to be implemented where long-term case management services, follow the minor patient.

The Review revealed that Monroe County currently does not have a mental health receiving facility equipped to address children with complex mental health issues, after being stabilized. The Review also revealed that Monroe County does not have any therapeutic group homes, foster homes, or children’s shelters to house children with complex mental health and substance abuse issues.
Implementation

- The Review Team has partnered with the Child Abuse Prevention and Permanency (CAPP) Plan to implement public awareness campaigns and educational programs that focus on infant safety, caregiving practices and safe sleeping environment for infants.

- The Review Team, at the request of the GAL, DCF, and CLS, recommends that the Court rule that Perpetrator’s dependency case remain open, once released from a rehabilitative program, for a minimum of 12-months.

- The Review Team, in conjunction with the DOH and DCF, provide drowning prevention education through the media and thorough training for staff.

- As a result of the fatal incident, a month later, Juvenile Dependency Court child placement procedures were revised. Records revealed that the Court will “conduct an evidentiary hearing prior to authorizing placement of any child, regardless of whether the proposed placement is with a parent (charged or uncharged), a relative, or non-relative. From this point forward the Court also requires that a thorough description of a families’ history be contained in every Dependency Shelter Petition. The commonplace bare bones “description” of prior allegations and their disposition will no longer suffice.”
Fatality Review Team Contact

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Questions or Comments!