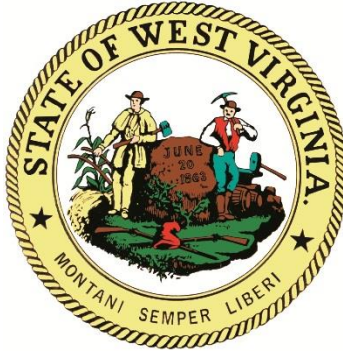




# WEST VIRGINIA DOMESTIC VIOLENCE FATALITY REVIEW PANEL ANNUAL REPORT

Calendar Year 2014  
(January–December)



**DOMESTIC VIOLENCE DEATHS  
IN WEST VIRGINIA  
2014**

**A Report of the West Virginia Domestic Violence Fatality Review Panel  
(WVDVFRP)**

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## **Acknowledgments**

The West Virginia Domestic Violence Fatality Review Panel extends its thanks and appreciation to all agencies and individuals that have assisted the Panel by submitting reports and information concerning fatal domestic violence events. Only through their cooperation can data be collected to determine the circumstances surrounding these incidents.

## **Introduction**

### **About the Panel**

The Fatality and Mortality Review Panel, specifically for this report, the West Virginia Domestic Violence Fatality Review Panel (WVDVFRP), is a statutory body enabled by the West Virginia Legislature under WV Code §61-12A-1. Team coordination and staff services are housed in the Office of the Chief Medical Examiner. The WVDVFRP is responsible for reviewing facts and circumstances surrounding all deaths that occurred in West Virginia of victims or suspected victims of domestic violence, including suicides, for those 18 years of age or older.

The WVDVFRP is required to provide statistical data and analysis concerning the causes of domestic violence fatalities in West Virginia, promote public awareness of the incidence and causes of domestic violence fatalities, as well as include recommendations for their reduction. The fundamental objective of the WVDVFRP is to prevent future homicides and suicides by providing necessary tools to families, individuals, and appropriate agencies. It is with great optimism that the WVDVFRP anticipates recommendations being utilized to make necessary changes to protect the victims and hold perpetrators accountable for their crime to reduce the number of domestic violence related deaths occurring in the state.

### **WVDVFRP Membership**

According to statute, the WVDVFRP operates under the auspices of the Office of the Chief Medical Examiner (OCME), with the State Chief Medical Examiner acting as the chair of the panel. The coordinator is housed within that Office as well. Other mandated members of the panel include:

- Four prosecuting attorneys or their designees;
- State Superintendent of the West Virginia State Police or his/her designee;
- One county law enforcement official;
- One municipality police officer;
- One physician, resident, or nurse practitioner specializing in the practice of obstetrics and gynecology;
- One adult protective service worker currently employed in investigating reports of adult abuse or neglect;
- One social worker who may be employed in medical social work;
- Commissioner of the Bureau for Behavioral Health and Health Facilities or his/her designee;
- Director of the Office of Social Services or his/her designee;
- One domestic violence advocate from a licensed domestic violence program;
- A representative of the West Virginia Coalition Against Domestic Violence;
- One physician, resident or nurse practitioner specializing in the practice of family medicine or emergency medicine;
- Director of the State Division of Corrections or his/her designee; and
- Director of West Virginia Health Statistics Center or his/her designee.

## **Types of Deaths Reviewed**

The WVDVFRP reviews cases where the manner of death is classified by the OCME as homicide, suicide, undetermined, or accident. The majority of cases the panel reviews fall into the following categories:

- Homicide committed by current or former intimate partner, current or former roommate, or family member following an act of domestic violence, sexual violence, or stalking, with or without a prior domestic history
- Homicide of perpetrator following an act of domestic violence, sexual violence, or stalking incident to include those caused by officer-involved shootings or by-stander intervention
- Suicide committed by a victim following an act of domestic violence, sexual violence, or stalking
- Suicide committed by a perpetrator following an act of domestic violence, sexual violence, or stalking

## **Case Review Process**

Initial screening of all fatalities is completed by the West Virginia Department of Health and Human Resources (DHHR), Bureau for Public Health (BPH), OCME to determine if they meet the definition for domestic violence. The OCME investigators, pathologists and the WVDVFRP Coordinator review all potential cases and make a determination of the domestic violence status based on information available at the time the case is first presented to the OCME. With this method of determination, it is possible some domestic violence cases may be overlooked occasionally as vital information is missing at the time of the initial review. In an attempt to identify domestic issues, an internet search is performed on West Virginia homicides and undetermined deaths, which sometimes results in the identification of additional domestic violence incidents.

The WVDVFRP Coordinator maintains a running list of all identified domestic violence fatalities which is reviewed by the entire WVDVFRP. The panel only reviews closed cases and does not attempt to reopen the investigation of those deaths. Closed cases are considered those where the offender is dead, has been convicted in a death, or there is a determination of no further legal action. For these reasons mentioned, most cases are reviewed approximately two years following the actual event.

Case reviews are conducted in confidential meetings. All panel members and invited guests are required to sign an agreement to abide by the confidentiality standards specified in the Fatality and Mortality Review Panel statutes.

Prior to case review by the WVDVFRP, a request for records is sent to all agencies identified as having relevant information. Collected information typically includes demographic information, autopsy reports, criminal and civil court histories of the victim and offender, other known history of intimate partner violence, media reports, information regarding the use of legal or advocacy services, and the details of the incident including those occurring both prior to and following the death.

The WVDVFRP members present a summary of the information collected for each case reviewed during the monthly meeting. This is followed by a panel discussion, which aims to address the following matters for each incident:

- Was the fatality the result of a domestic incident as defined by the State statute?
- What were the perilous events that led up to the fatality?
- Were there any opportunities to prevent the fatality?
- Is training or education needed as it relates to specific areas of occupations?
- How does the incident relate to other reviewed incidents?
- Are there policies relevant to the incident that need to be reviewed or changed?
- Are there lessons or educational messages to be derived from this incident?

As part of the review, the WVDVFRP identifies which systems, if any, the victim and/or the offender had contact with prior to, during, or after the death. This information helps the panel identify possible recommendations for improvement to system responses to domestic violence. This method of constructing system recommendations does not in any way have the intention to place blame on any individual or organization. To further support this prerogative, recommendations made throughout the year are assembled and presented as wide-ranging proposals for systemic improvements as opposed to case specific ones. It is with optimism that the panel believes that these recommendations can be used to improve system responses across an array of agencies and service providers to reduce or eliminate domestic violence deaths in West Virginia.

## Findings

This report focuses on only a portion of calendar year 2014 domestic violence related fatalities that occurred in West Virginia, among men and women aged 18 years and older. For 2014, there were 114 possible domestic violence cases identified for panel review. To date, the panel completed review of 60 of those cases; and of those, 31 were determined to be deaths resulting from domestic violence.

The National Coalition Against Domestic Violence (NCADV) defines domestic violence as the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetuated by one intimate partner against another [1]. This violence could include behaviors such as stalking, intimidation, threats, physical violence, sexual violence, emotional abuse, psychological abuse, or economic deprivation [1]. The DVFRP does not limit the definition of domestic violence to intimate partners only. The definition includes family members as well as roommates sharing a dwelling.

### Demographics

In 2014, a majority of the domestic violence deaths reviewed by the panel were males. Figure 1 shows the percentage of deaths that were male compared to the percentage of deaths that were female. Twenty of the 31 deaths reviewed were males while 11 of the 31 deaths reviewed were females. Data for West Virginia differ from what is generally seen nationally as current data show a higher rate of males. This number could change in the future once all 2014 domestic violence deaths are reviewed. Nationally, the NCADV shows that on average one in three women

and one in four men have been abused by an intimate partner [1].

**Figure 1: Domestic Violence Deaths By Gender**

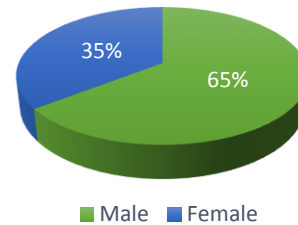
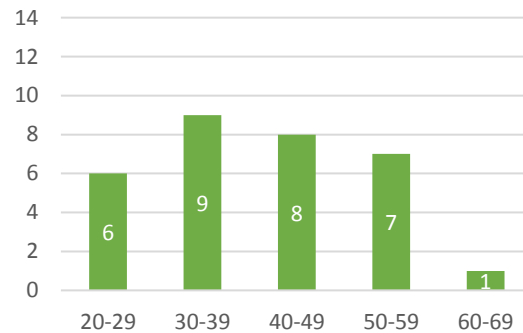


Figure 2 shows the domestic violence deaths by age. Age groups used were 10 year increments. The ages of domestic violence victims in West Virginia ranged from the youngest being 20 years old to the oldest being 61 years old.

**Figure 2: Deaths By Age Group**



When looking at deaths by race, almost all of the decedents were Caucasians. Figure 3 shows that 90%, or 28 of the reviewed decedents, were Caucasians. The remaining 10%, or three of the reviewed decedents, were African American.

**Figure 3: Deaths By Race**

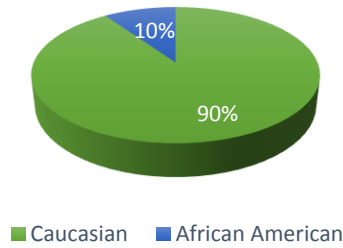


Figure 4 shows the deaths by both race and gender. Caucasian male deaths accounted for 58.1%, or 18 deaths, followed by Caucasian females accounting for 32.3%, or 10 reviewed deaths. African American males accounted for 6.4%, or two deaths, and African American females accounted for 3.2%, or one of the deaths.

**Figure 4: Deaths By Race and Gender**

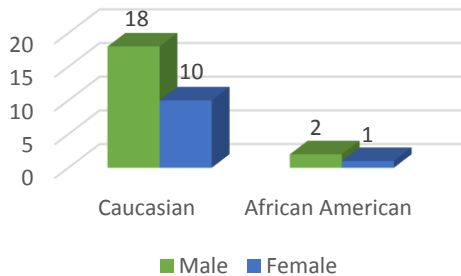
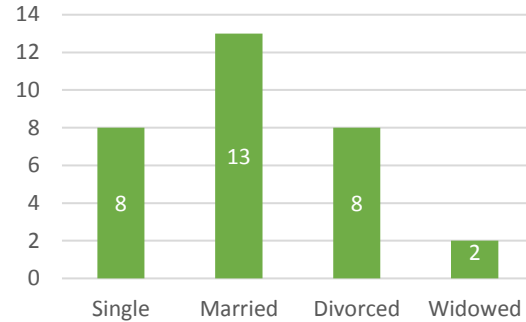


Figure 5 shows deaths distributed by marital status. It is important to note that a marital status of single denotes that the individuals were not married at the time of death, but could have been in a relationship. This information shows that a majority of the reviewed deaths (42%) were among married couples. An equal amount of single (26%) and divorced (26%) individuals died as a result of domestic violence. Widowed individuals (6%) were the least likely to die from domestic violence related deaths. Four of the 13 married deaths occurred in married individuals who were recently separated or in the process of a divorce. National data state

that women are most vulnerable to violence when separated from their intimate partner or during divorce [2].

**Figure 5: Deaths By Marital Status**



**Manner of Death**

Manner of death is broken into three categories: accident, suicide, and homicide. Figure 6 shows that most of the domestic violence deaths that were reviewed in West Virginia in 2014 were suicides. Sixteen of the 31 reviewed deaths, or 52%, were determined to be suicides. This was followed closely by homicides at 45% with 14 reviewed deaths reviewed falling within that category. One death (3%) was determined to be an accident.

**Figure 6: Deaths By Manner**

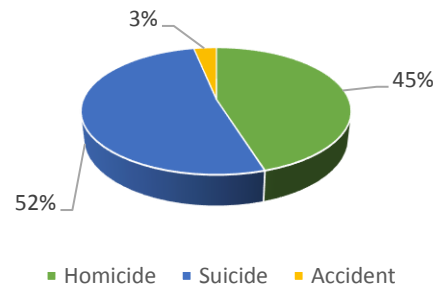
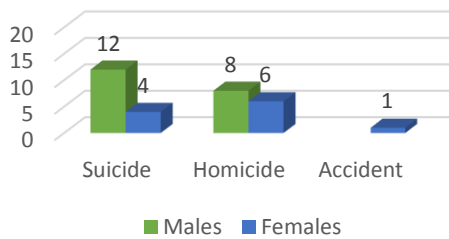


Figure 7 shows the manner of death by gender. The data show that males are most likely to commit suicide when related to domestic violence deaths. Male suicides were three times as likely as females and accounted for 39.0% or 12 reviewed deaths. Female suicides accounted for 13.0% or four



of the deaths reviewed. The number of homicide deaths was similar. Males were more likely to die from a homicide than females. Male homicides accounted for 26.0% or eight deaths and female homicides accounted for 19.0% or six deaths. Accidental deaths were the least likely to occur, at 3.0% of the total deaths reviewed. There was only one death determined to be an accident and it was a female.

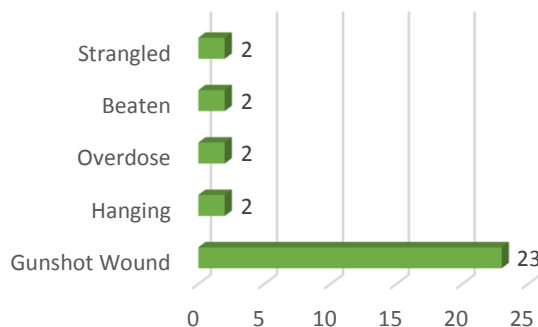
**Figure 7: Manner of Death By Gender**



**Cause of Death**

Within each manner of death, there are subdivisions termed causes which give a more detailed explanation as to why the death occurred. There were five causes for reviewed domestic violence related deaths that occurred in West Virginia in 2014, as seen in Figure 8. The most prevalent cause of death was gunshot wounds, which accounted for 23 deaths or 74.0% of all reviewed deaths. The other causes of death accounted for two deaths each or 6.5% each.

**Figure 8: Cause of Death**



**Distribution of Deaths for Various Categories**

Figure 9 shows the reviewed to date domestic violence related deaths that occurred in West Virginia, in 2014, by county. Most deaths occurred in Kanawha County with five reported deaths, followed by Cabell County, which had four. There were 38 counties that did not have any reported domestic violence related deaths at the time of the report. These numbers are raw numbers for the reported deaths per county and did not take into account the population size of each county.

**Figure 9: Number of Deaths Per County**

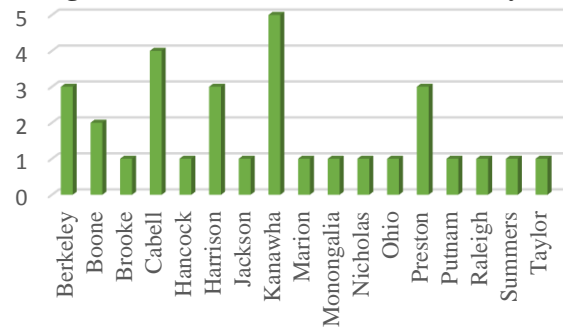


Figure 10 shows the number of domestic violence deaths in which there was a known domestic violence history between the perpetrator and the victim. This shows that 71%, or 22 of the 31 deaths reviewed, had a prior domestic violence history. Only 29%, or nine of 31 reviewed deaths had no known history.

**Figure 10: History of Domestic Violence**

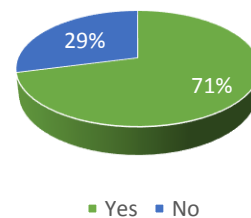


Figure 11 shows the number of victims that had an active domestic violence protection order at the time of their death. This shows that even though they were taking steps to separate themselves from the abuser, it was not enough to save their lives. National data show that a victim's risk of being killed significantly increases while in the process of leaving or after they have recently left [2].

**Figure 11: Active DVP at Time of Death**

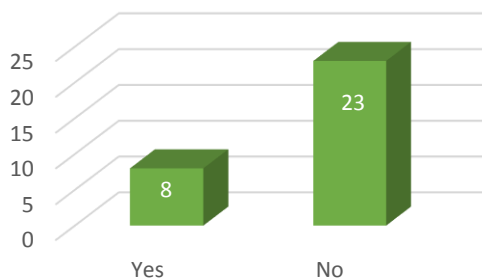
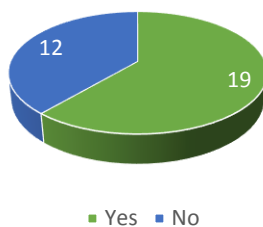


Figure 12 shows the amount of people that were involved in an argument prior to their death. Nineteen of the 31 people were known to have an argument at the time immediately preceding their death.

**Figure 12: Involved In Argument Prior To Death**



Another possible correlation is the amount of domestic violence related decedents that were known to have a mental illness. Figure 13 shows that almost half, 14 of the 31 reviewed deaths, had diagnosed mental health issues. Mental illnesses identified ranged from depression to bipolar disorder.

**Figure 13: Victim Had Mental Health Issues**

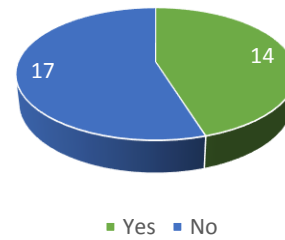


Figure 14 shows the substance abuse status of the domestic violence decedents. A little more than half, or 16 people, were not known to use either drugs or alcohol at any time prior to their deaths. An equal number of people used alcohol and drugs. There were seven people that were known to be drug users and seven people that were known to abuse alcohol.

**Figure 14: Known Substance Abuse History**

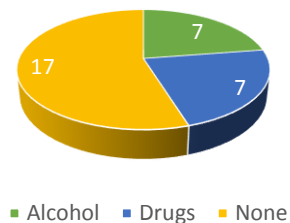
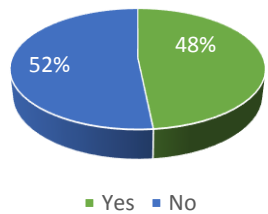


Figure 15 shows a very important statistic related to domestic violence related fatalities. The figure shows the number of deaths that had children present. Almost half, or 48%, of the deaths had children present at the time of the fatal incident. Fifteen of the 31 deaths reviewed had at least one child present. This is a major issue, as research has shown that children who experience childhood trauma, including domestic violence, are at a greater risk of tobacco use, substance abuse, obesity, cancer, heart disease, depression, and unintended pregnancy [3].

**Figure 15: Child Present at Time of Death**



**Data Limitations**

Domestic violence fatalities reviewed by the DVFRP were determined to meet the definition of domestic violence set forth in the West Virginia State Code. Some fatalities reviewed may have had elements of domestic violence identified in the victims' lives but could not be determined that domestic violence was linked to the cause of death. This accounts for the discrepancy between the 60 cases reviewed and the 31 cases determined to be domestic violence deaths as a result of review. The DVFRP does not claim that all domestic violence related fatalities that occurred in the reporting year have been identified. The DVFRP still needs to review the remaining 54 identified possible domestic violence deaths and determine the domestic violence relationship.

## **2014 West Virginia DVFRP Recommendations**

1. The WVDVFRP recommends a centralized coordinator that would work to ensure that law enforcement response is consistent and conducted in accordance with West Virginia laws and Legislative rules. This includes one office to be established to coordinate the response statewide. This would be an office that could communicate and collaborate with all the systems and disciplines by employing a person(s) who would coordinate trainings and best practices based on the best examples from around the state and across the nation. By creating a collaborative environment, that includes the West Virginia Coalition Against Domestic Violence, the West Virginia Foundation for Rape Information Services, the Domestic Violence Fatality Review Team, all STOP Teams, all Sexual Assault Response Teams, and Title IX offices, a victim could expect the same comprehensive response anywhere in West Virginia.
2. The WVDVFRP recommends a change in the West Virginia code to allow the panel to review domestic violence deaths in more detail. The panel would like to interview family members of the victims or perpetrators to gain pertinent information that is not always gathered from other sources.
3. The WVDVFRP recommends that a representative from the Department of Veterans' Affairs be added to the panel to participate in reviews. The panel believes that this would help with gathering information about past military service of perpetrators and victims.
4. The WVDVFRP recommends that it be granted access to the Domestic Violence Offender Registry as it would help the panel gather more information on victims and perpetrators.
5. The WVDVFRP recommends an updated awareness campaign for Domestic Violence, which would include exploitation of the elderly.
6. The WVDVFRP recommends the implementation of lethality training for the regional jails. The panel believes that this would allow intervention to be made at that point that could potentially save a life.
7. The WVDVFRP recommends increasing training for law enforcement in order to increase awareness of domestic violence and elder abuse. The panel believes that law enforcement generally see domestic violence as being between intimate partners but that is only a portion of the actual domestic violence cases.
8. The WVDVFRP recommends continuation and expansion of the Kanawha County Pilot Project with the magistrate court where one judge handles all cases of a domestic violence offender. This allows the judge to see the entire history of the offender and make sure that sentences are appropriate to the crimes committed.
9. The WVDVFRP recommends that prosecuting attorneys include no access to firearms as a standard condition of bond. The panel believes that the limitation of access to firearms for offenders could potentially reduce the number of firearm related deaths.
10. The WVDVFRP recommends that more services are offered to families of victims. This would include access to scene cleanup as well as grief counseling free of charge. The panel believes that there are a limited number of these types of services currently available in the state.

11. The WVDVFRP recommends that a change be made to current Adult Protective Services policies to include contacting law enforcement when there is a reasonable suspicion of abuse, neglect, or exploitation even in cases that are not substantiated during their assessment.
12. The WVDVFRP recommends better communication methods be developed within all aspects of the Bureau for Children and Families.

## References

1. National Coalition Against Domestic Violence. Domestic Violence National Statistics. Accessed online at: [www.ncadv.org](http://www.ncadv.org)
2. Callie Marie Rennison (1101). Intimate Partner Violence and Age of Victim, 1993-1999. Bureau of Justice Statistics Special Report. Washington DC: U.S. Department of Justice. NCJ #187635. Estimates are provided from the National Crime Victimization Survey, which defines an intimate partner as a current or former spouse, girlfriend, or boyfriend. Violent acts include murder, rape, sexual assault, robbery, aggravated assault, and simple assault.
3. Felitti, V.J., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine*, 14(4): 248-58. Centers for Disease Control and Prevention and the Kaiser Permanente's Health Appraisal Clinic, San Diego, CA. Available at <http://www.cdc.gov/NCCDPHP/ACE/index.htm>.