



**INDIANA DOMESTIC
VIOLENCE FATALITY
REVIEW TEAM**

**Report on 2015 Domestic
Violence Fatalities**



FOREWORD

In 2015, over eighty percent of the intimate partner homicides in Indiana were committed using a firearm. The mere fact that a gun is present during an incident of intimate partner violence increases the lethality exponentially. We also note the significant number of children who were murdered as a result of intimate partner violence. It is clear that we can and must do better. Early intervention for lower level intimate partner violence cases with certified batterer's intervention programs and surrender of firearms enforced for any disqualified individuals are essential.

Statutorily, we review these cases to recommend systemic changes in order to save lives in the future. Morally, we review these cases to ensure that no life has been lost to intimate partner violence in vain and to honor every victim and their story. Please read this report and join us in our mission to stop intimate partner violence in the state of Indiana.

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PROJECT OVERVIEW

From January 1st to December 31st of 2015, intimate partner violence in Indiana led to the death of 32 individuals in 23 incidents. There were 7 incidents involving multiple fatalities, 2 incidents where multiple children were murdered, and 3 police-involved shootings. Those killed were adults and children, women and men, victims of intimate partner violence and those who used violence against their partners, bystanders and family or friends of victims of abuse. Fatalities were recorded in 13 Indiana counties. Twenty-six of the 32 people killed were killed with a gun. It is critical to state that this report details only those deaths that we can definitively link to intimate partner violence. There were additional fatalities and incidents that we strongly believe have intimate partner violence as the root cause. Unfortunately, many homicides go unsolved, many injuries and conditions caused by intimate partner violence can appear to be something else, and many deadly incidents are qualified as something different. So, while we strongly believe that there are other deaths that should be included in this report, the information provided focuses only on those confirmed cases.

In 2017, the Indiana Coalition Against Domestic Violence worked with our state legislature to revise Indiana's domestic violence fatality review statute, and House Enrolled Act 1516 took effect on July 1st. Among the significant updates to the previous law was the creation of a statewide domestic violence fatality review team tasked with reviewing fatalities due to intimate partner violence in jurisdictions where there was not an active local fatality review team, and issuing a biannual statewide report on domestic violence fatalities along with systemic recommendations to improve the response to intimate partner violence across the state of Indiana. The Indiana State Domestic Violence Fatality Review Team (IN DVFRT), as named by Governor Eric Holcomb, convened in November of 2019. The IN DVFRT is comprised of 11 members representing key stakeholder communities mandated by the legislation itself. Members represent domestic violence advocacy agencies, prosecutors, law enforcement, healthcare professionals, coroners, as well as the Indiana Department of Health and other key state agencies. The team is coordinated by the Indiana Coalition Against Domestic Violence, whose primary purpose is to ensure that the voices of survivors and victims are always at the forefront of every conversation.

As the team convened, there were many areas where they believed they could make direct impact in ending intimate partner violence. However, with the multitude of challenges set before them by the global COVID 19 pandemic, the IN DVFRT focused their energy on their primary task; compiling and issuing this initial report on intimate partner fatalities by the end of 2020. The IN DVFRT selected 2015 as the focus of this report based on several factors. It was hoped that the intervening 4-5 years since the incidents would allow for the majority of the involved criminal cases to be concluded. Additionally, the Indiana Violence Death Reporting System (INVDRS) database records begin in 2015. The intent was to use the INVDRS as a major data source for the initial investigation of reports. The ultimate intent of this report is to use the information gathered to identify strategies to prevent future loss of life. To that end, this report will ultimately function as an introduction to a deeper review and evaluation of trends in intimate partner violence and resulting homicides, as well as strategies to address those emerging issues which will be released by this team at the end of 2021. With the understanding that Indiana's domestic violence homicide rate jumped 86% during the initial months of the pandemic, work to reduce and eliminate domestic violence homicide is more urgent than ever.

Respectfully submitted,

Caryn C Burton, MS
Training Coordinator - ICADV
Indiana Domestic Violence Fatality Review Team Coordinator



DEFINITIONS

In generating this report, we use the terms domestic violence or intimate partner violence to characterize forms of abuse perpetrated within the context of a current or former romantic relationship. Intimate partner violence and domestic violence are used interchangeably.

ICADV defines **domestic violence** as a pattern of coercive or abusive behavior in a relationship that is used to gain and/or maintain power and control over an intimate partner. It includes emotional, psychological, economic, physical or sexual actions or threats of action used to influence the thoughts, feelings or actions of another person. This includes behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame or injure the target.

Domestic Violence Related Homicide; For the purposes of this report, the Indiana Domestic Violence Fatality Review Team chose to report on those deaths perpetrated in the context of, resulting from, or motivated by violence in a relationship between current or former intimate partners. Such deaths include:

- **Decedent;** individual who died as a result of the incident
- **Intimate Partner/Spouse;** individual currently or previously engaged in an intimate relationship with predominant aggressor; this person is also often referred to as the survivor or victim in relationship to abusive incidents
- **Predominant Aggressor;** the individual in the relationship who exercises power and control over their partner using coercive or abusive acts to elicit a change in behavior from the survivor/victim
- **Child;** individual under the age of 18 either biologically related to or under the care of the intimate partner/spouse and/or predominant aggressor
- **Homicide;** where one partner kills another in the context of an abusive relationship
- **Homicide/Suicide;** where the predominant aggressor kills the victim and then dies by suicide
- **Predominant Aggressor Death;** these deaths include defensive action undertaken by the intimate partner/spouse, a bystander, or law enforcement in the course of a violent incident that results in the death of the predominant aggressor
- **Suicide;** where the predominant aggressor or intimate partner/spouse dies as a result of self-inflicted injury in the context of an abusive relationship
- **Bystander Death;** includes deaths of individuals other than the intimate partner/spouse occurring in the context of an intimate partner assault - such deaths during the period of this report include deaths of strangers, friends, and family members
- **Romantic Rival Death;** where the target either was, or was believed by the perpetrator to be, involved in a romantic relationship with the perpetrator's current or former intimate partner



METHODOLOGY

The Indiana Domestic Violence Fatality Review Team (IN DVFRT) was convened in November 2019 and is tasked, per House Enrolled Act 1516, with three primary duties. Those duties are identifying trends and fact patterns concerning deaths due to domestic violence in Indiana, using the data gathered in identifying trends and patterns to recommend strategies for the prevention of injuries to and deaths of domestic violence victims, and to advise and educate the general assembly, governor, and public on the status of domestic violence fatalities in Indiana. Membership of the IN DVFRT is guided by state statute and appointed by the office of Governor Holcomb based on recommendations from the Indiana Coalition Against Domestic Violence (ICADV). A complete list of the IN DVFRT members is included in the acknowledgements of this report. The IN DVFRT identified as its first step to issue an initial report on domestic violence fatalities during a selected year, 2015, with the intent to use the data gathered for that initial report to examine each incident more intently and to issue recommendations based on those full reviews within 12 months of the release of the initial report.

Deaths related to intimate partner violence occurring in 2015 were identified via a combination of media research and stakeholder reports. ICADV utilizes a number of media search services, receiving regular notifications of all web-based reports that include key words related to intimate partner or domestic violence. Additionally, community-based advocates working in domestic violence service provider agencies notify ICADV when deaths related to intimate partner violence are identified in their service areas. ICADV staff members compile a list of these deaths annually and submit the draft list to service providers statewide for review, correction, and addition if needed. The final list is reviewed and revised by ICADV staff and provided to the IN DVFRT as an initial data-gathering tool.

Using the final approved list of domestic violence related deaths, ICADV staff and IN DVFRT members worked to collect official data sources to validate information about the dynamics and circumstances around each incident provided by media accounts. ICADV staff conducted internet searches for public records and solicited case information from key informants. Specific data sources used in the compilation of this report include coroner's verdicts, autopsy reports, law enforcement reports, court records, appellate records, community fatality review team records, and information provided by community domestic violence advocates.



REPORT CHALLENGES

The primary challenge in undertaking the review process and drafting this report continues to be our ability to fully identify and then thoroughly evaluate all of the identified incidents and deaths. The challenge begins with the lack of a consistent statewide data source. As was previously mentioned, the IN DVFRT intended to use data requested from the Indiana Violent Death Reporting System (INVDRS) as a primary source to confirm domestic violence as a

factor involved in the deaths. However, upon requesting data from INVDRS, we were informed that the domestic violence indicators included in the database are optional and provided no data for 2015 when queried. This meant that the only place from which we had to begin our search for records was the list compiled by ICADV, which is primarily comprised of media reports. Therefore, before we could begin to review and evaluate incidents, we first had to fully confirm the circumstances of each incident and determine if the death or deaths were, in fact, related to intimate partner violence.

Ultimately, the lack of a consistent statewide data source particularly to identify domestic violence related deaths severely hampers our efforts. The IN DVFRT clearly recognizes and acknowledges that, while the 32 deaths addressed in this report are traumatic and 32 too many, not all the deaths which occurred as a result of intimate partner violence during 2015 have been counted. During our data-gathering and review process, there were incidents which had to be struck from the list because we were unable to obtain enough information to confirm that intimate partner violence was a factor in the death. Also, though ICADV works tirelessly to identify all intimate partner violence related deaths, it is likely that some are inadvertently missed. Specifically, we may have missed deaths where the original circumstances were suspicious but not identified by the media or law enforcement as related to intimate partner violence. Additionally, suicides related to intimate partner violence, particularly if not committed in the context of a homicide/suicide, are very difficult to identify and investigate.

The second challenge continues to be the lack of consistent access to records to confirm and further investigate domestic violence fatalities. An additional revision to Indiana's domestic violence fatality review statute was the inclusion of language specifically allowing for the provision of specific agency records for the purpose of review under the law. This was done intentionally to address this barrier for domestic violence fatality review teams across the state. During our review for this report, seeking records directly from system agencies – law enforcement, coroner's offices, and the Department of Child Services – netted roughly about a 70% return rate. While this is a marked improvement over previous years, it still creates significant barriers to a thorough review of the data. Additionally, the reports that are received from various agencies are highly inconsistent. Where one jurisdiction may provide a full record of the case file, another jurisdiction will provide only a redacted police report with no supplemental information. Or where one coroner will provide a full autopsy record complete with narrative, another will only provide the coroner's verdict. Accordingly, with the current sources available, the information provided about each incident is a compilation of all available sources and is minimal.

An additional challenge in the review and drafting of this report comes in the overall newness of the team itself. As a group, the IN DVFRT is newly formed and inexperienced at the process of domestic violence fatality review. While some individual members have experience with fatality review, the team as a whole is new to the process and still figuring out our roles and process. This was further complicated by the replacement of three members through the course of the roughly 9-month process of creating this report. However, as with any new collaboration, those challenges will continue to work themselves out as we move forward and engage both with each other and with the process.

Of course, the final challenge faced in the drafting of this report was and continues to be the COVID19 pandemic and resulting restrictions. Every aspect of our lives has been altered in

some way by the public health crisis. Specifically speaking to the challenges experienced by our team, fatality review is a collaborative process that requires coming together to review and discuss information. While technology can facilitate some conversations, accommodating long intense discussions of traumatic events via videocall is an adjustment. Additionally, transmitting massive report files while maintaining the integrity of the data and respecting the confidentiality of those involved took some time to put in place. Members of the IN DVFRT should be commended for their continued patience, dedication, and flexibility.

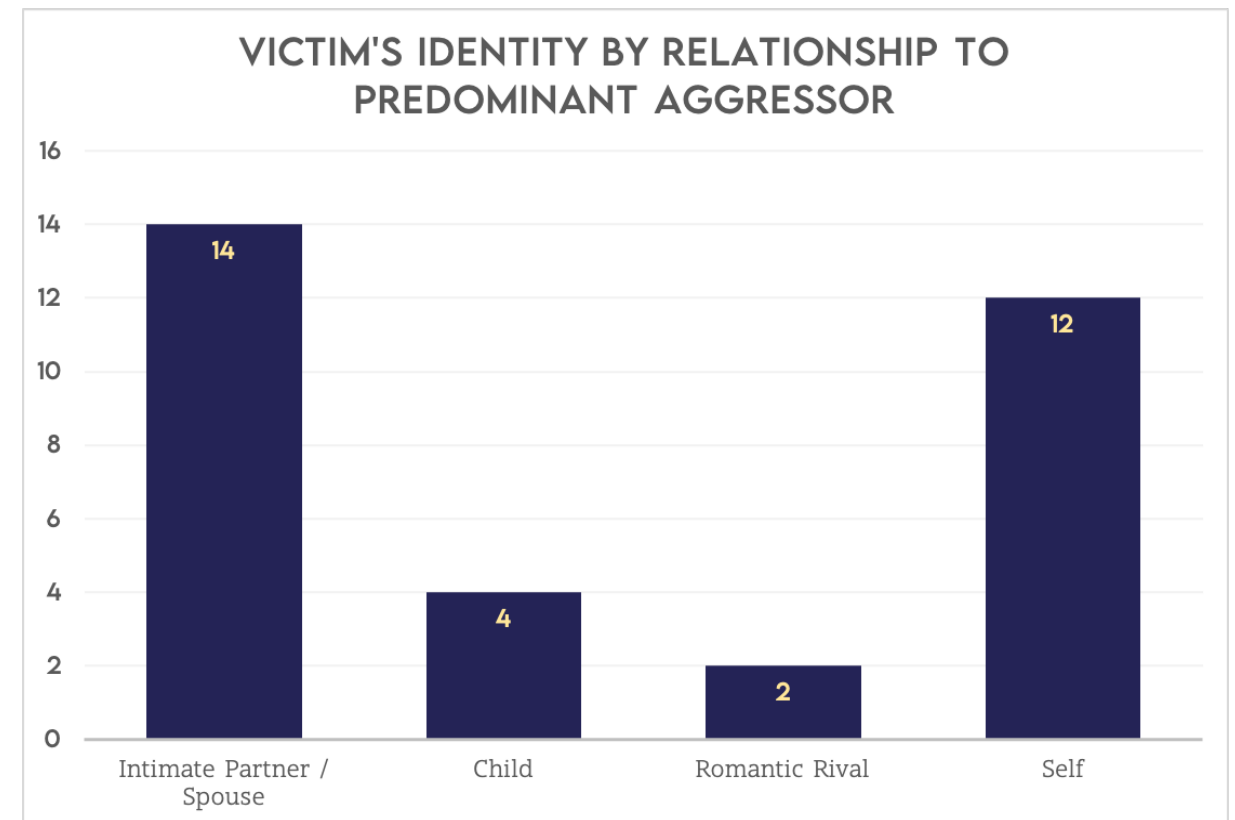


DOMESTIC VIOLENCE DATA & ANALYSIS

of Incidents: 23

of Deaths: 32

** Unless otherwise indicated, the numbers listed in the charts below indicate the number of individuals who fall in that category.

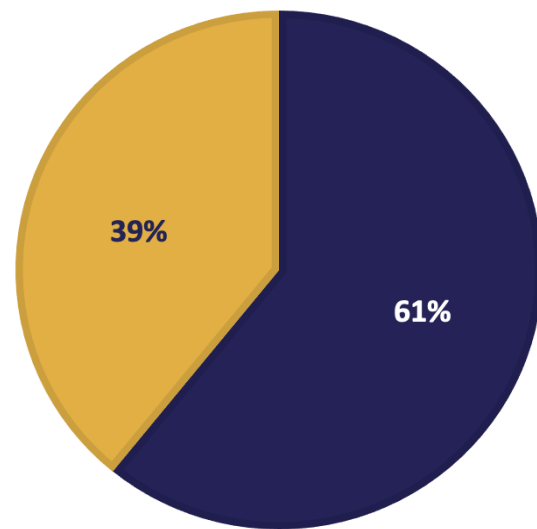


DECEDENTS – RELATIONSHIP TO PREDOMINANT AGGRESSOR:

This chart illustrates the general identity of those killed as a result of intimate partner violence in 2015 as expressed by their relationship to the predominant aggressor. There were 32 individuals killed. Of those, 14 were the intimate partner or spouse, 4 were children, 2 were romantic rivals, and 12 were the predominant aggressors themselves.

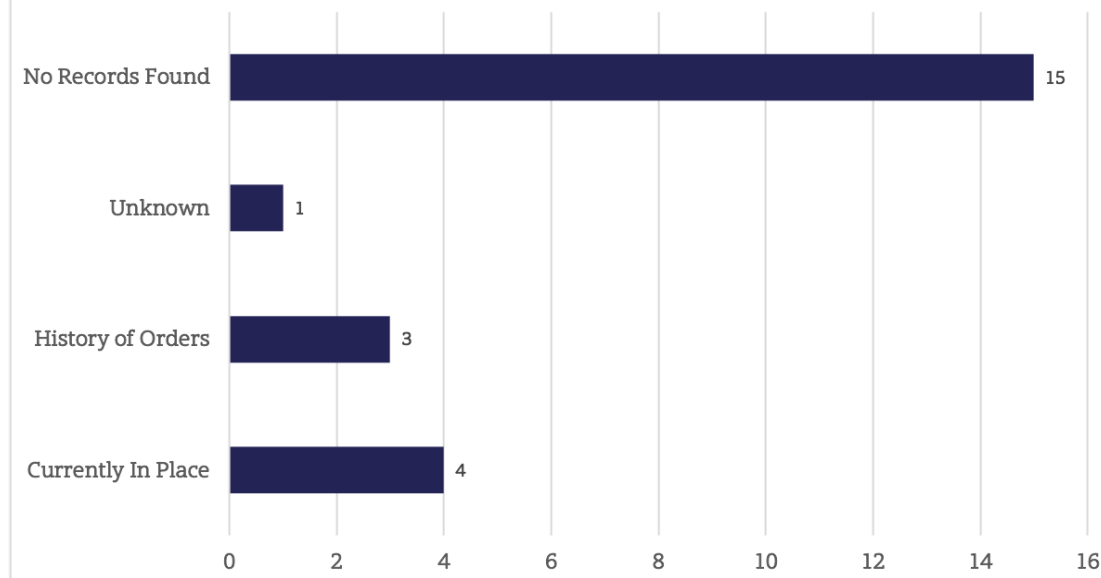
RELATIONSHIP STATUS AT TIME OF INCIDENT

■ Active Relationship ■ Estranged or Ended



RELATIONSHIP STATUS: This chart illustrates the status of the intimate partner relationship that was at the core of the 23 different incidents when each one occurred. The relationship was quantified as over or estranged when official steps of separation were noted in the reports. Official acts of separation include moving out of shared home, filing for divorce, or informing friends or family of the end of the relationship. By default, if none of those steps could be identified, the relationship was quantified as active.

PROTECTIVE ORDERS BETWEEN PARTIES

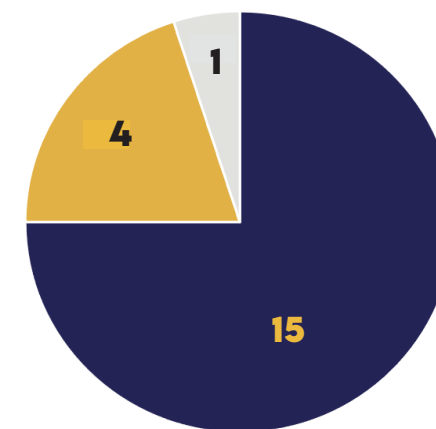


HISTORY OF PROTECTIVE ORDERS: This chart illustrates the prevalence of a history or presence of current Protective Orders in cases that ended in a fatal incident. Cases were noted as having a history of Protective Orders regardless of the manner of dispensation of the Order, ie whether or not it was dismissed or had expired.

MANNER OF DEATH:

MANNER OF DEATH - VICTIMS OF VIOLENCE

■ Firearm ■ Stabbed ■ Strangulation

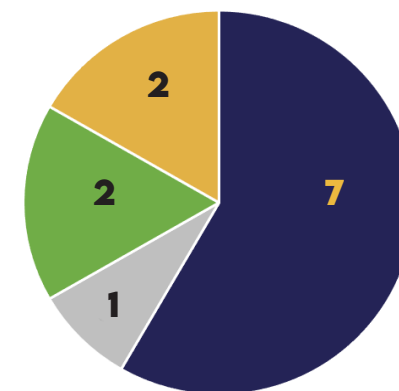


Victims of Violence

This chart illustrates the manner or method of death for those individuals killed who were other than the predominant aggressor. This accounts for 20 of the 32 individuals who died, including 4 children.

MANNER OF DEATH - PREDOMINANT AGGRESSOR

■ Suicide by Firearm ■ Suicide by Hanging
■ Police-Involved Shooting ■ Firearm - Shot by Abused Partner

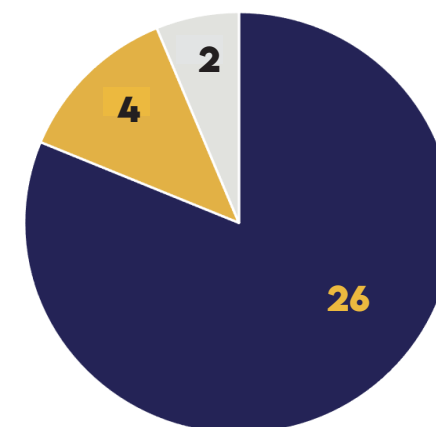


Predominant Aggressor

This chart illustrates the manner of death for those individuals identified as predominant aggressors who were killed during incidents. As is indicated, the majority of those who died killed themselves after killing or attempting to kill their intimate partner and/or their children.

MANNER OF DEATH - ALL DECEDENTS

■ Firearm ■ Stabbed ■ Asphyxiation / Strangulation



All Decedents

This chart illustrates the manner of death overall for all individuals killed in incidents resulting from intimate partner violence during 2015. As is clearly evident, a gun is the most used weapon in domestic violence related fatalities, whether by homicide or suicide.

OVERVIEW OF DECEDENTS

The chart below provides basic biographical information for 32 individuals whose death could be confirmed as due to intimate partner violence in Indiana in 2015. In previous reports, it was standard to include a brief summary of each incident that resulted in a death or deaths. After discussion, the IN DVFRT determined that including this information could be retraumatizing for family members or friends of victims. The decision was made to remove those summaries in favor of minimal biographical data to minimize any possible trauma while still providing an overview of the toll of intimate partner violence related fatalities.

County	Age	Sex	Weapon / Manner	Relationship to Perpetrator	Records on File
Bartholomew	33	F	Firearm	Intimate Partner or Spouse	Coroner's report; Law enforcement full report; DCS Report
Bartholomew	39	M	Firearm - Suicide	Self	Coroner's report; Law enforcement full report; DCS Report
Delaware	55	M	Stabbed	Romantic Rival	Coroner's report; History of protective orders between parties
Harrison	35	F	Firearm	Intimate Partner or Spouse	DCS Report
Harrison	38	M	Firearm - Suicide	Self	DCS Report
Henry	5	M	Firearm	Child	Protective order in place; DCS Report
Henry	11	F	Firearm	Child	Protective order in place; DCS Report
Henry	48	M	Firearm - Suicide	Self	Protective order in place; DCS Report
Howard	44	F	Firearm	Intimate Partner or Spouse	Coroner's report
Howard	46	M	Firearm - Suicide	Self	Coroner's report
Huntington	34	M	Firearm - Suicide	Self	Coroner's report
Madison	25	M	Stabbed	Romantic Rival	Coroner's report; Protective order in place
Marion	20	F	Firearm	Intimate Partner or Spouse	Coroner's report; Law enforcement probable cause only

Marion	27	M	Firearm	Intimate Partner or Spouse	Coroner's report; Law enforcement probable cause only; History of protective orders
Marion	36	F	Firearm	Intimate Partner or Spouse	Coroner's report; Law enforcement probable cause only
Marion	55	F	Strangulation	Intimate Partner or Spouse	Coroner's report; Law enforcement probable cause only
Marion	41	F	Firearm	Intimate Partner or Spouse	Coroner's report; Law enforcement probable cause only
Marion	28	F	Firearm	Intimate Partner or Spouse	Coroner's report; Law enforcement probable cause only
Marion	34	M	Firearm	Self	Media reports; No official law enforcement reports but confirmation of self defense
Marion	35	F	Firearm	Intimate Partner or Spouse	Coroner's report; Law enforcement probable cause only; DCS Report
Monroe	25	M	Firearm	Self	Coroner's report
Monroe	21	F	Stabbed	Intimate Partner or Spouse	Coroner's report; Law enforcement redacted report only
Monroe	20	M	Asphyxiation - Suicide by Hanging	Self	Coroner's report; Law enforcement redacted report only
Orange	3	F	Firearm	Child	DCS Report; History of protective orders
Orange	6	M	Firearm	Child	DCS Report; History of protective orders
Orange	37	M	Firearm - Suicide	Self	DCS Report; History of protective orders
Orange	49	M	Firearm - Police-Involved	Self	Coroner's report; Law enforcement full case report

Porter	23	F	Firearm	Intimate Partner or Spouse	Coroner's report; Law enforcement full case report; DCS Report
Porter	31	F	Firearm	Intimate Partner or Spouse	Coroner's report; Law enforcement full case report; DCS Report
Porter	38	M	Firearm - Suicide	Self	Coroner's report; Law enforcement full case report; DCS Report
Shelby	56	M	Firearm - Police-Involved	Self	Media reports only
St Joseph	58	F	Stabbed	Intimate Partner or Spouse	Coroner's report



NEXT STEPS

The Indiana Coalition Against Domestic Violence and the Indiana Domestic Violence Fatality Review Team recognize this report as a first step in the process of a full and complete review of intimate partner violence related deaths. The IN DVFRT will use the foundational data gathered for this report to identify trends and areas of concern that warrant a deeper examination in how they impact those effected by intimate partner violence and the community at large. The IN DVFRT will use the next 12 months to critically examine those areas and draft and release what we believe will be immediately impactful recommendations to address those concerns.

In addition to work on what amounts to Part 2 of this report, the IN DVFRT is concluding work on a statewide model strangulation response protocol. This response protocol was one of the recommendations that came from the previous report issued by the advisory council which was doing the work of the statewide team prior to its incorporation into the legislative mandate. The IN DVFRT determined during the initial meetings of the team that the strangulation protocol was a critical recommendation from their predecessors that should be completed and implemented. As strangulation within intimate partner violence continues to be a growing and highly dangerous form of violence used against survivors of intimate partner violence, the IN DVFRT chose the strangulation protocol as the first strategy to put forth. The strangulation protocol is in the final revision stages, and the IN DVFRT hopes to release it during the first quarter of 2021.

Finally, the IN DVFRT will begin performing active case reviews of recent intimate partner violence deaths that have occurred in Indiana. The team will begin with in-depth reviews of cases identified through this report, but will also include cases where reviews have been requested by surviving family members or agency partners. It is the ultimate purpose and goal of the Indiana Domestic Violence Fatality Review Team that, through systematic review of deaths related to intimate partner violence, strategies can be identified and put into action to ultimately eliminate domestic violence fatalities altogether.



ACKNOWLEDGMENTS

As the coordinating agency for the Indiana Domestic Violence Fatality Review Team, ICADV expresses their profound gratitude to the members of the IN DVFRT for their contributions to the research and drafting of this report. Team members are:

Melissa Arvin, JD - Indiana Supreme Court, Office of Court Services

Barbra Bachmeier, JD, MSN, APRN, NP-C - Medical Practitioner

Amy Blackett, JD - Indiana Prosecuting Attorneys Council

Caryn C Burton, MS - Indiana Coalition Against Domestic Violence

Jon M Frain - Pulaski County Coroner

Melissa Haaff - Hope's Voice

Kim Lambert - Indiana Criminal Justice Institute

Terri Lee, MPH - Indiana State Department of Health, Office of Women's Health

Nicholas Neal, MLEA, MPA - Geminus, Corp.

Kelly L Owens - Indiana Department of Child Services

Tiffany Woods - Indianapolis Metropolitan Police Department

The Indiana Domestic Violence Fatality Review Team expresses its gratitude to all of the stakeholder agencies who provided records and reports to the team to aid in our compilation, review and drafting of this report. Those agencies include:

Allen County Coroner's Office

Bartholomew County Coroner's Office

Delaware County Coroner's Office

Henry County Coroner's Office

Howard County Coroner's Office

Huntington County Coroner's Office

Lake County Coroner's Office

Madison County Coroner's Office

Marion County Coroner's Office

Monroe County Coroner's Office

Porter County Coroner's Office

St Joseph County Coroner's Office

Vigo County Coroner's Office

Allen Co Police Dept

Bloomington Police Dept

Columbus Police Dept

Gary Police Dept

Henry Co Sheriff's Dept

Indiana State Police Department - Jasper Region

Indianapolis Metropolitan Police Dept

Monroe Co Sheriff's Dept

Porter Co Sheriff's Dept

Indiana Department of Child Services

ICADV also wishes to acknowledge the work of community-based fatality review teams throughout the state of Indiana. The dedication and collaboration of all team members is crucial to our ability as a community to end the trauma of intimate partner violence.

And, finally, a very heartfelt and profound thank you to ICADV administrative assistant Kelly Grey for her indispensable help at every stage of researching and creating this report. Without her intelligence, compassion, and 3 extra sets of hands, this report would not exist.

