Iowa Domestic Abuse Death Review Case Findings and Recommendations

2017 – 2018 (Published 2023)

Prepared by The Iowa Department of Health and Human Services on behalf of the Iowa Domestic Abuse Death Review Team

Iowa Domestic Abuse Death Review

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Foreword

The Iowa Domestic Abuse Death Review Team was created in 2000 to review domestic abuse- related homicides and suicides in the state. Legislative authorization is given in the Code of Iowa Chapter 135.108 and in the Iowa Administrative Code 641-91.

The specific purpose of the team is "…to aid in the reduction of the incidence of domestic abuse deaths by accurately identifying the cause and manner of deaths occurring from domestic violence and by making recommendations for changes in policy and practice to improve community interventions for preventing domestic abuse deaths."

A domestic abuse death means a homicide or suicide that involves or is a result of an assault as defined in section 708.1 (Iowa Code) and the parties involved were:

- current, separated, or former spouses,
- current or former cohabiting partners,
- parents of the same minor children,
- current or former dating partners,
- related by blood or affinity to someone in the same household or workplace, or
- subject to an order of protection between the perpetrator and victim.

The team meets four to six times per year, and members are appointed by the director of the Department of Public Health in consultation with the Attorney General. The Chief Justice of the Iowa Supreme Court appoints two team members. There are nine government agency liaisons assigned to the team, who also serve as full team members. Administrative support is provided by the Department of Health and Human Services.

The team responsibilities include:

1. Preparing a biennial report for the governor, supreme court, attorney general, and the general assembly concerning:
    a. The causes and manner of domestic abuse deaths, including an analysis of factual information obtained through review of domestic death certificates and domestic abuse death data,
    b. The contributing factors of domestic abuse deaths, and
    c. Recommendations regarding the prevention of future domestic abuse deaths, including actions to be taken by communities.
2. Advising and consulting the agencies represented on the team regarding program and regulatory changes that may prevent domestic abuse deaths.
3. Developing protocols for domestic abuse death investigations and team review.

The case reviews done by the team focus on reviewing the circumstances that occurred in the relationship between the intimate partners that led up to the death(s); including contact the couple may have had with the criminal justice system, community professionals, or other community systems. This is done to determine what risk factors may have been present to indicate lethality and if there were prior opportunities for intervention. The type of records requested for each case include: newspaper articles, birth and death certificates, autopsy reports, law enforcement investigative reports, 911 call logs, arrest histories, court records, crime victim assistance applications, corrections files, medical records, victim service records, and school or protective services records when children are involved. The findings are based on the information that is documented in the records received, and not all records are received for each case. Additional note: As a matter of consistency, the team has chosen to use the term “domestic violence” throughout the report to refer to the physical and emotional behaviors used by an intimate partner against the other in an attempt to control the partner’s actions and maintain the relationship.

Executive Summary

There were 24 cases reviewed between January 2017 – December 2018. Domestic violence (DV) impacts individuals from all communities. In case review we examine data available by case, searching for trends and possible contributing factors. Percentages provided are based on the number of cases for which data is available. Cases without known demographic areas were removed from the total. When case percentage is compared to the overall percentage of Iowa's population, possible health inequities can be identified.

The following trends continue from prior reports;

1) The most lethal time for domestic violence victims is when they are preparing to leave or have left the relationship.
    a. Strategies to address this;
        i. Pro-active safety planning
        ii. Interventions that stabilize the person at greatest risk for harming the other
        iii. Economic support and cash assistance programs for both parties
        iv. Affordable housing and housing assistance for both parties when a no contact order or protective order are issued
2) History of violence used to address conflicts or a lack of non-violent problem-solving skills.
    a. Strategies to address this;
        i. Social-emotional learning,
        ii. Home visitation programs,
        iii. Traumatic brain injury screening and referral for services
3) Mental health concerns which can be linked to adverse childhood experience, poverty, and family history of abuse (child abuse, sexual abuse, and domestic abuse)
    a. Strategies to address this;
        i. Mental health and social support to men and boys
        ii. Safe gun storage available in the community when someone has made suicidal threats or statements like, "if I can't have you, no one will."

CONTRIBUTING RISK FACTORS

To be included under these case findings the team determined there was enough information identified to categorize as a risk factor that contributed to the domestic abuse death.

Risk Factor Category	Percent of cases present
History of violence or recent increase in violence	**83%**
Mental health concern	**71%**
Relationship ending	**50%**
Economic hardship	46%
History of sexual violence	46%
History of criminal legal system intervention	46%
Isolation – estranged from family, limited social support system	42%
Access to firearms – owner, permit to carry, obtained new guy permit, or new purchase 30 days prior to homicide	38%
Controlling behavior and jealousy present	29%
History of relationship instability (children with a previous romantic partner)	21%
Prior suicide attempts	17%
Prior child abuse (suspected or founded)	17%
10+ year age gap between romantic partners	17%
High stress present	17%
At least one person had a disability	17%
Low educational attainment or HS dropout	17%
Stalking/harassment	17%
Rural residency	13%
Medical condition or recent surgery	13%
Pending court case	8%
Protective Order or No Contact Order issued	8%
Threats of violence	8%

Rigid gender norms	8%

OPPORTUNITIES FOR INTERVENTION

To be included under these case findings the team determined there was enough information identified in case materials that a social support or system-based provider/responder had contact with either party at some point prior to the homicide. Some explicitly were aware the abuse was occurring. Settings are considered with priority setting and recommendations.

Social or System Setting	Percent of cases present
Family	**42%**
Law Enforcement or Courts	**42%**
Medical Providers (Hospitals, Emergency Departments, Clinics)	**29%**
Workplace (co-worker or employee)	25%
Friend	17%
Spiritual/Faith Community	17%
Substance Use Treatment	17%
DHS – Child Protection Worker	17%
Neighbors or roommates	17%
Mental health provider	13%
Iowa Domestic Abuse Program	8%
Schools (Guidance counselor)	8%
Community service provider (meals on wheels)	8%
Veteran's Affairs	8%
Disability service provider	8%
Gun and ammunition distributors	4%
Foster care	4%
Dentists	4%
Victim services	4%
Prenatal care provider	4%
Medicine management provider	4%

Case Findings

DEMOGRAPHIC INFORMATION

GENDER

Of the 24 cases reviewed during this report period, the majority of persons killed by a current or former partner/spouse were female. The majority of those causing these fatalities were male.

Figure 1.

Gender of person murdered by a current or former romantic partner of spouse

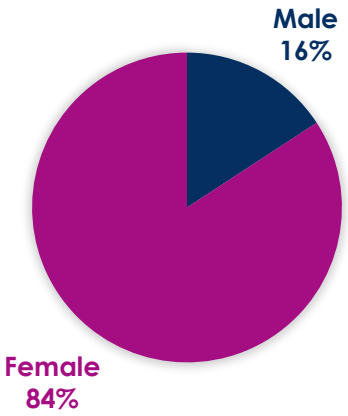
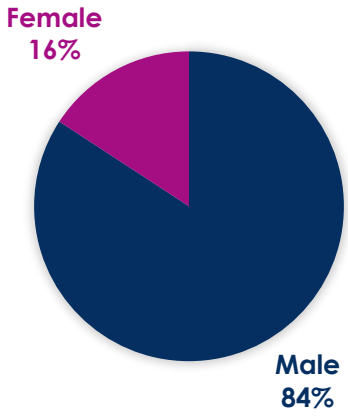


Figure 2.

Gender of person who murdered a current or former romantic partner of spouse



AGE

Iowans ages 18 – 25 were the highest age group represented in the cases reviewed.

Figure 4. Age of Decedent

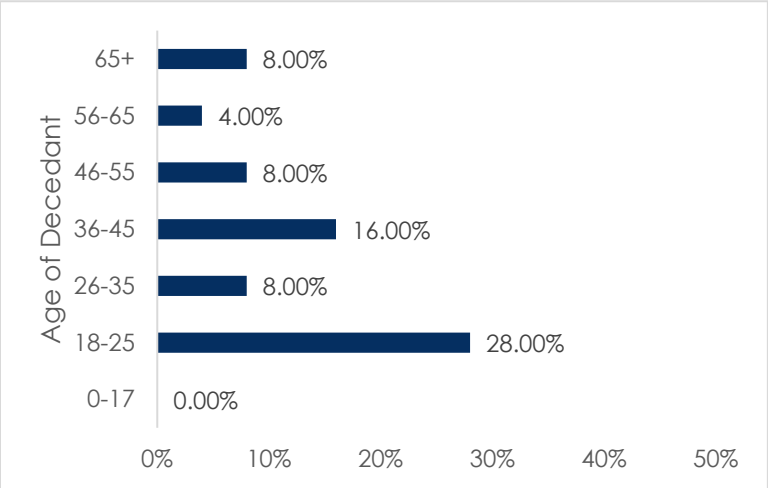
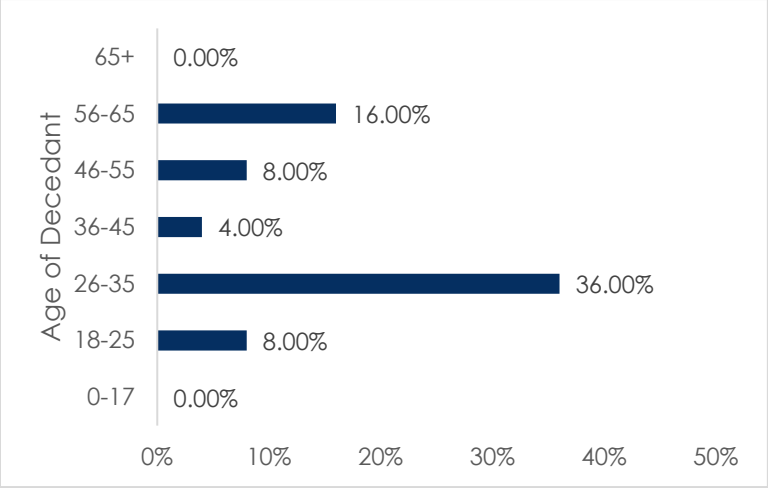


Figure 5. Age of Person causing harm

Iowans ages 26 – 35 were the highest age group represented in perpetrating domestic abuse homicides.



RACE/ETHNICITY

Iowa is home to more than 3 million people. The following figures show 2020 census data for race/ethnicity compared to Iowa Domestic Abuse Death Review decedents.

Figure 6: 2020 Iowa Census Data

Subject	Percent
White alone (not Hispanic or Latino)	84.1%
Hispanic or Latino	6.7%
Black or African American	4.3%
American Indian and Alaska Native	.6%
Asian alone	2.8%
Native Hawaiian and Other Pacific Islander alone	0.2%
Two or More Races	2.1%

When looking at the percentage of homicide decedents by race/ethnicity, we see that white Iowans account for the majority of domestic deaths. When looking at percentage of those who caused harm by race/ethnicity, we find the majority are also white. However, Black/African Americans are disproportionately represented compared to their percentage in the total population (Figures 7 & 8). Investing in culturally specific programming which strengthens support to Black/African American families and develops non-violent problem-solving skills are recommended. One example is "A Call to Men."

Figure 7: 2020 Per Capita race/ethnicity of Decedents

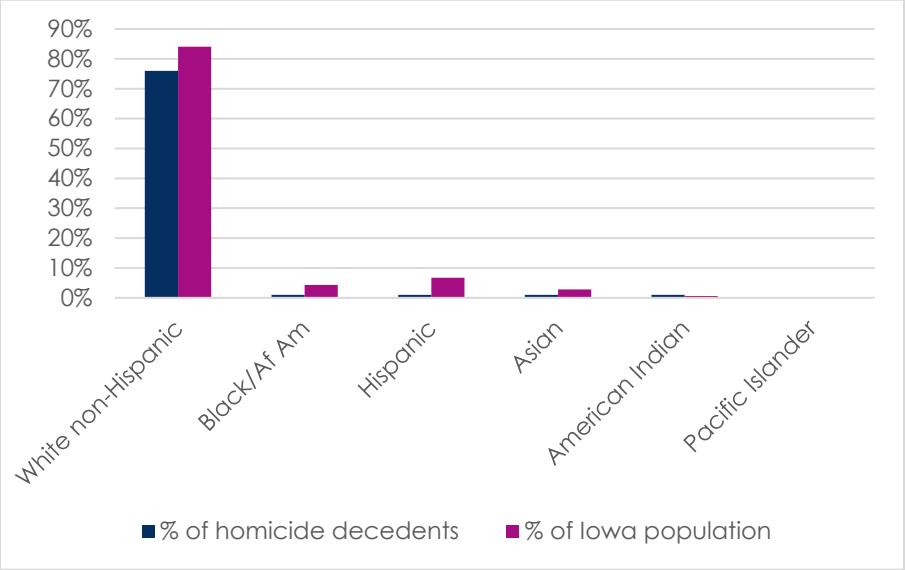
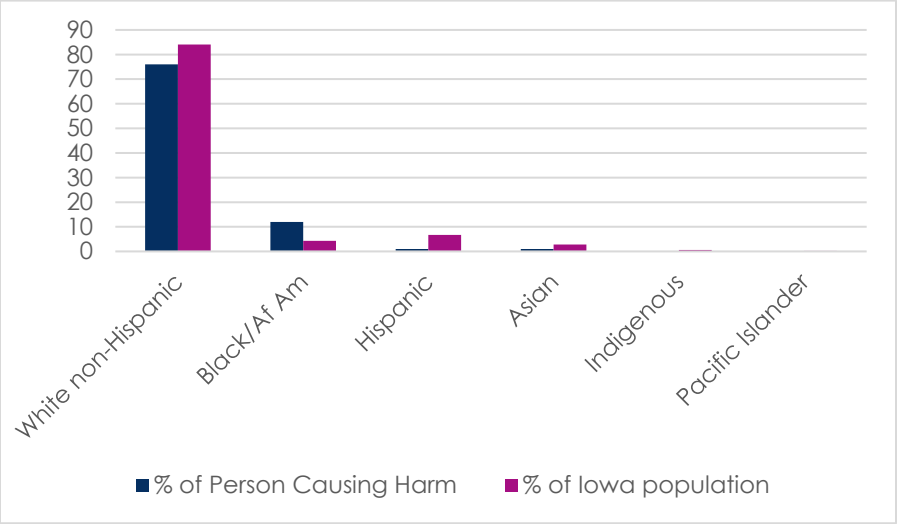


FIGURE 8. PER CAPITAL RACE OF PERSON CAUSING HARM



EDUCATION

Information for all of Iowa was compiled from the 2020 Iowa Gender Wage Equity Study. Educational attainment was identified as a risk factor in the majority of cases.

As outlined in Figure 10 below, those with a HS diploma or less were responsible for the majority of domestic homicides. This could mean a few things; 1) educational attainment increases protective factors which prevent causing domestic abuse homicides, 2) factors related to dropping out of HS or not pursuing degrees such as poverty, disability, trauma, lack of supportive/caring adult, cost of housing, and other life circumstances could contribute to a person being at greatest risk for using violence to solve problems.

Figure 9 Educational Attainment Distribution for Iowa by Gender

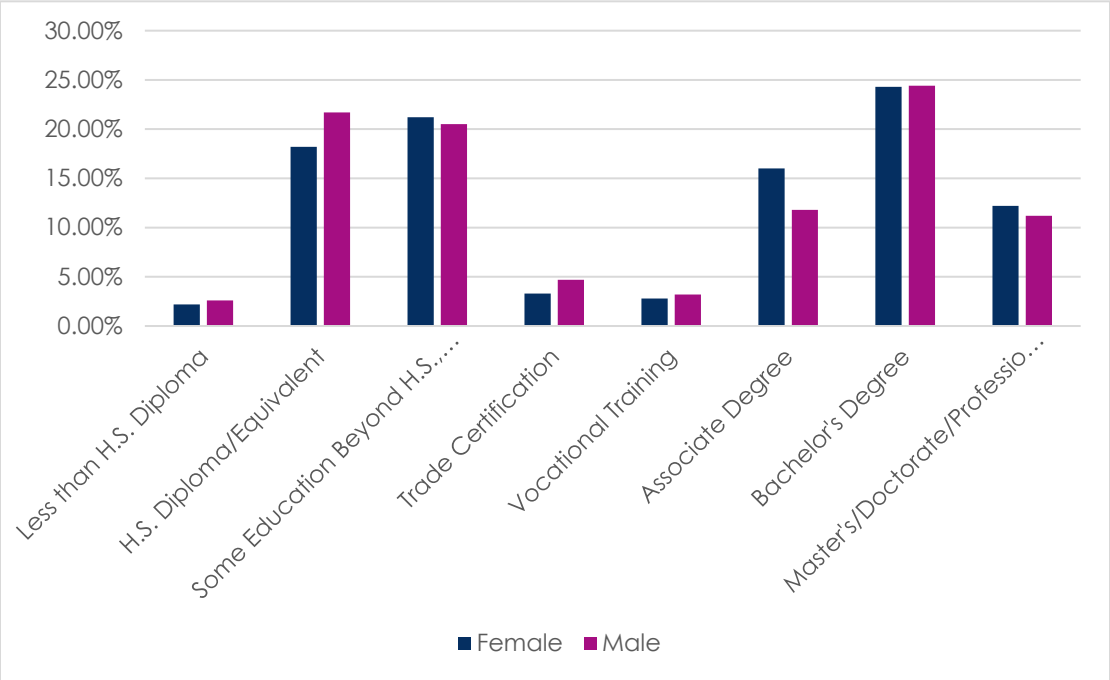
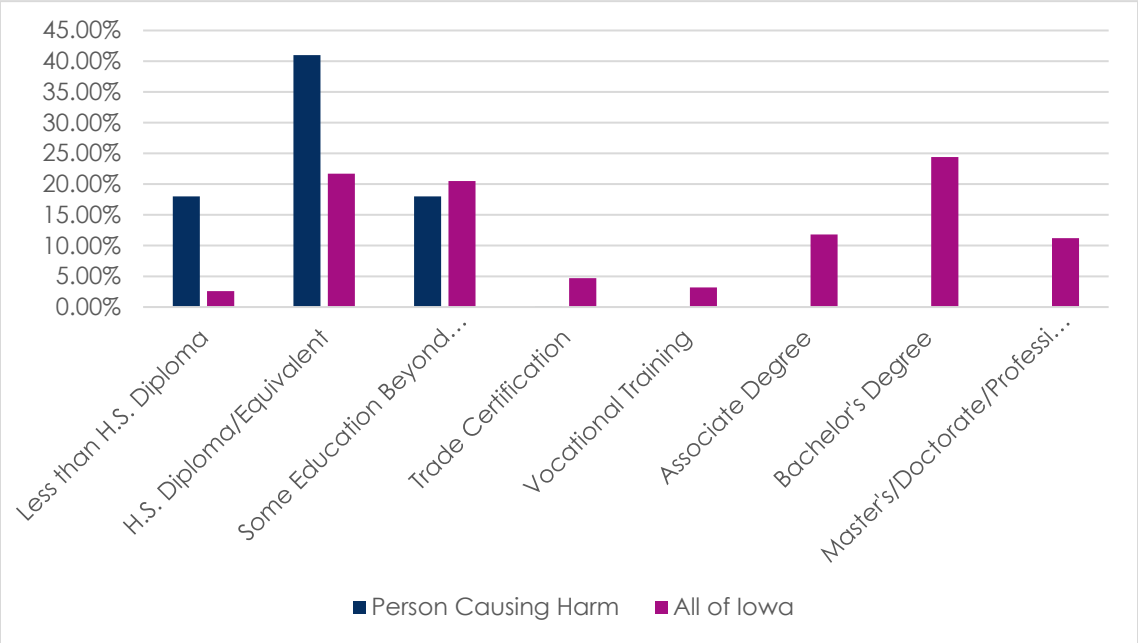


Figure 10 Educational Attainment of Person Causing Harm



CAUSE AND MANNER OF DEATH

Firearms remain the primary method of homicide in Iowa. Followed closely by stab wounds and strangulation. The higher representation of strangulation data may indicate that training on the subject has increased law enforcement documentation and identification.

FIGURE 11. CAUSE OF DEATH

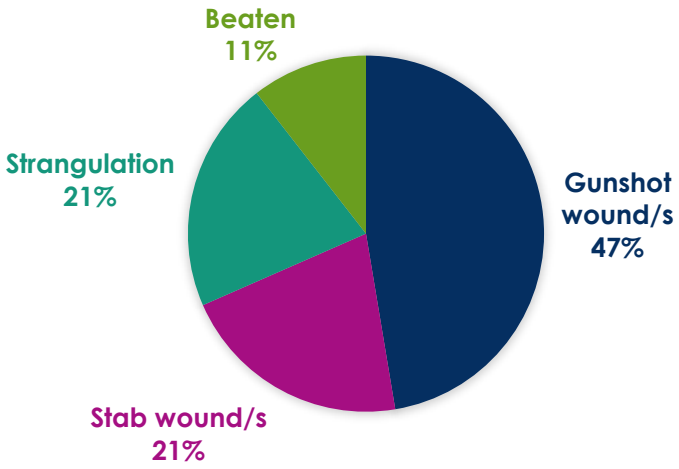
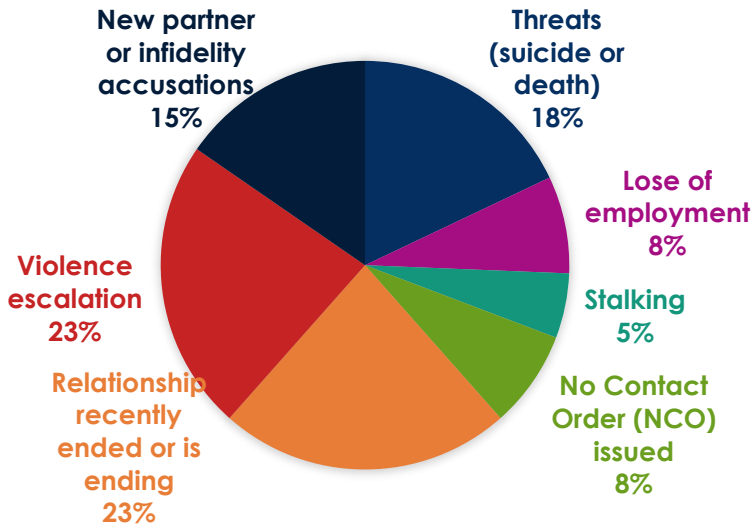


FIGURE 12. CIRCUMSTANCES PRIOR TO HOMICIDE



RECOMMENDATIONS FOR PREVENTION BY SETTING

The following are recommendations generated by the team specific to addressing risk factors and opportunities for intervention in the case materials reviewed

		APPLICABLE SETTING		
PREVENTION ACTIVITY	EXAMPLES	COMMUNITY	SYSTEMS	POLICY MAKERS
Culturally specific services	Funding for culturally specific programming Rural specific programming Refugee services Healing centered engagement	X	X	X
Mental health services	Mobile crisis services Suicide survivor support Payment for schools providing students with mental health services	X	X	X
Community education and awareness	Healthy relationships Home visitation Mental health Guan safety trainings Economic empowerment Cash assistance and community benefits programs Safety planning to include vehicles	X	X	X
Adapt policies and protocol about responding to domestic violence	Workplace's respond to Domestic and Sexual Violence National Resource	X	X	X
Improved communication between systems	Collaboration between victim services and substance use treatment		X	

Offender accountability	offenders should be put on supervision after being charged with a sex offense		X	

APPENDIX

IOWA DOMESTIC ABUSE DEATH REVIEW TEAM

HISTORY

Original legislation to establish a statewide domestic abuse death review team was introduced by the Senate Human Resources Committee in March 1997 (SF 459). It was voted on and passed in the Senate on March 24 th. The bill was sent to the House, and referred to Human Resources. It was recommended for passage, however, was not placed on the calendar for Vote that session and was referred back to the Human Resources Committee.

During the 1998 legislative session, a bill was not passed out of the House Human Resources Committee, but language was added to the department of public health's appropriation bill (SF2280, section 5, subsection 4(10)) directing the department to promulgate rules for a domestic abuse death review team modeled after the child death review team. Those rules were drafted, adopted, and became effective January 6, 1999 (IAC 641-91). The department proposed legislation (HSB 185) for the 1999 legislative session to establish the death review team by Code as well as administrative rule. HSB 185 was referred to Human Resources and was not passed out of committee. Rules are located in the Iowa Administrative Code [641] Chapter 91.

The department proceeded with the establishment of the team through the authority of administrative rule, and pre-filed legislation for the 2000 legislative session.

Professional associations and state agencies submitted recommendations for team members to the director of public health, and the director made appointments in December 1999. The first meeting of the Iowa Domestic Abuse Death Review Team was held on Friday January 28 th , 2000. Without clear statutory access to confidential records, the team proceeded with orientation of members and development of team procedures.
House File 2362 was passed by the 78 th General Assembly and signed by the Governor in April 2000. The bill became effective July 1, 2000 and the team began reviewing case records after that date. Code of Iowa Chapter 135.108-135.112 provides the statutory authority for the team.

The team is staffed by the Iowa Department of Health and Human Services. Daylong meetings are held quarterly in Des Moines. The Team issues reports to the Legislature, Governor and Attorney General biennially.

Further information about the Iowa Domestic Abuse Death Review Team may be obtained by contacting:

DOMESTIC ABUSE DEATH REVIEW TEAM
LUCAS STATE OFFICE BUILDING
321 EAST 12 TH ST.
DES MOINES, IOWA 50319-0075

IOWA DOMESTIC ABUSE DEATH REVIEW TEAM: 2017 - 2018