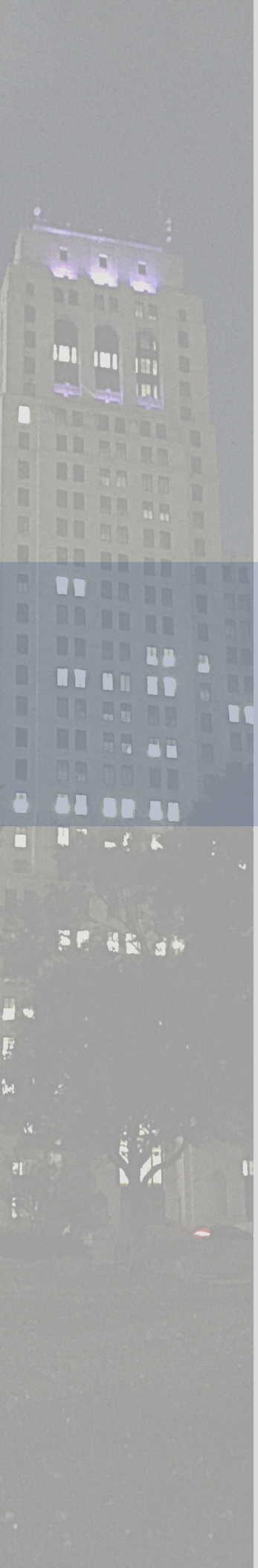

NYS Domestic Violence Fatality Review

Report to the Governor and Legislature
June 2021

NEW YORK STATE
Office for the Prevention of Domestic Violence

NYS Office for the Prevention of Domestic Violence

The Office for the Prevention of Domestic Violence (OPDV), created in 1992, is the country's only executive level state agency dedicated to the issue of domestic violence. It replaced the former Governor's Commission on Domestic Violence established in 1983. Our mission is to improve New York State's response to and prevention of domestic violence with the goal of enhancing the safety of all New Yorkers in their intimate and family relationships. OPDV is located in Albany, New York.

DEDICATION

The New York State Domestic Violence Fatality Review Team would like to dedicate this report to the women, men and children who have lost their lives due to domestic violence, to their surviving loved ones, to those individuals who continue to live with domestic violence every day and to the responders and service providers who work to end domestic violence in our communities.

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FROM THE EXECUTIVE DIRECTOR

As Executive Director of the New York State Office for the Prevention of Domestic Violence (OPDV), I am pleased to present this report of the NYS Domestic Violence Fatality Review Team. The report contains information gathered by the team through 25 individual reviews in communities across New York State – urban, rural, and suburban. The work of the team is intense, in-depth, interdisciplinary, and confidential. Fatality review teams do not determine who is "to blame" for a homicide or near-death. Individual cases and communities are never identified. Instead, insights gained by the team are used to improve responses to all cases of domestic violence, with the knowledge that such improvements have the potential to prevent future deaths. We look forward to expanding this report in the years to come as we continue to make recommendations to enhance the response to domestic violence in New York State.

Kelli Owens
Executive Director

NYS Domestic Violence Fatality Review Team

NYS OPDV

Ellen C. Schell ***Mary M. Walsh***

Team Members

Theresa Brickey
NYS Dept of Corrections and Community Supervision

Yaritza Colliton
NYS Office of Victim Services

Nathaniel Fields
Urban Resource Institute

Linda Glassman
NYS Office of Temporary and Disability Assistance

Gary M. Govel
NYS DCJS
Office of Probation and Correctional Alternatives

Fredric I. Green
Westchester County DA's Office

Brian C. Hogan
Albany Police Dept

Michael A. Iapoce
Ulster County Dept of Social Services

Allison Ives
NYS Dept of Health

Victoria Martuscello
New York State Police

Connie Neal
NYS Coalition Against Domestic Violence

JaHarr Pridgen
Buffalo City Court Judge

Elizabeth Santiago
Center for Safety & Change

Lisa C. Smith
NYS Office of Court Administration

Johanna Sullivan
NYS Division of Criminal Justice Services

Jara Traina
NYS Office of Children and Family Services

Karen Ziegler
Albany County Crime Victim and Sexual Violence Center

NYS Domestic Violence Fatality Review Team Overview

The NYS Domestic Violence Fatality Review Team was established through legislation signed by Governor Cuomo on October 25, 2012. The team conducts a confidential, in-depth analysis of deaths or near-deaths that result from domestic violence. The goal of the review is not to find fault or to blame anyone for the death. The goal is to learn from these very difficult cases in an effort to identify ways to improve the overall response to domestic violence, with an eye toward preventing similar tragedies in the future.

The NYS Office for the Prevention of Domestic Violence administers the team, which is comprised of representatives from state and local agencies involved in work related to domestic violence. Team members include law enforcement, domestic violence and crime victim programs, legal services, sexual assault services and healthcare providers, among others. The team reviews case records and conducts interviews with family members and offenders who are willing to provide information to the team.

The information from case records and interviews is used to create a detailed timeline containing all relevant information available. Background of both the victim and offender will include such things as previous relationships, criminal history in addition to the domestic violence and domestic violence incidents leading up to the homicide. The team uses the timeline to guide its review of the case.

The timeline the team creates is likely the first time anyone is looking at all available case information at one time. Putting all the information together gives a more complete picture and is a helpful tool for the team to identify gaps in the response and where interventions may have helped.

Reviews are conducted in the location where the death or near-death occurred.[1] Responders involved in the case are invited to meet with the team to discuss the case and answer any questions arising from the team's review of case records. After each review, the team sends follow-up information to meeting attendees, which may include recommendations based on the group discussion.

The work of the team is strictly confidential. The team does not publicly identify the cases it reviews, or even where reviews are conducted. Local responders who participate in reviews are asked to maintain that confidentiality as well. As such, team members and local responders who attend the reviews sign a confidentiality agreement prior to each meeting. No information shared with the public is case-specific.

[1] While the team's reviews are usually conducted as in-person meetings, two reviews were done virtually due to New York State travel and meeting restrictions associated with the COVID-19 pandemic.

The team's mission is to conduct detailed reviews of domestic violence deaths and near-deaths in a multidisciplinary, confidential and culturally-sensitive manner, using the information learned to develop comprehensive recommendations for improved system response to domestic violence, with the goal of enhancing safety for victims and accountability for offenders. The objectives of the team are to:

- **Identify systematic gaps and barriers to service;**
- **Promote greater coordinated community responses to domestic violence; and**
- **Increase awareness by educating the public, service providers, and policymakers about domestic violence fatalities and intervention and prevention strategies.**

Cases Reviewed

The team generally conducts 4 reviews per year and has reviewed 25 cases since 2013. Cases are either referred by outside individuals/entities or chosen by the team, as discussed further below. Cases that are referred are given priority. (Appendix A)

According to the enabling statute, cases reviewed by the team must involve deaths or near-deaths caused by a family or household member, as defined in Family Court Act §812 or Criminal Procedure Law §530.11. They must be closed cases with no ongoing court proceedings or investigations.

The team selects cases based on factors including case dynamics and location. Because New York State is geographically diverse, the team reviews cases from urban, suburban and rural areas within all regions. The team also tries to review cases with as many diverse elements as possible, including cases that involve older individuals, college campuses, individuals who identify as LGBTQIA+, officer-involved domestic violence, and cases that involve the workplace.

Since the team often selects cases based on verifiable systems involvement and other factors, cases reviewed do not represent a random sample of domestic violence homicides. As such, the team's findings are for informational purposes and should not be viewed as representative of all domestic violence homicides.

Red Flags

Lethality assessment involves the use of commonly recognized indicators, or “red flags," to determine whether a domestic violence victim is at increased risk of being killed by their intimate partner. Lethality assessment tools, like the Danger Assessment and variations thereof, are used by domestic violence advocates, police officers and others across New York State. In fact, the most recent revision of the NYS Domestic Incident Report (DIR) includes questions designed to help officers assess potential lethality. While lethality assessments should not be the only method of assessing dangerousness, they can be useful for those who are properly trained in how to conduct and implement them.

The presence of a gun in a home where there is domestic violence increases the risk of homicide by 500%.

Campbell, et.al. 2003. “Risk Factors for Femicide in Abusive Relationships: Results From a Multisite Case Control Study.” American Journal of Public Health July: 93(7).

The team identifies common red flags to assess patterns and responses that may be common in domestic homicides. Some red flags were likely unknown to responders, because the team has access to more information after the fatality. Red flags are noted here only as information that might be helpful in future cases.[2]

76% of female homicide victims had been stalked by the person who killed them.

54% of the victims reported stalking to police before they were killed by their stalkers.

89% of the victims who had been physically abused had also been stalked in the 12 months before the murder.

Stalking Resource Center, The Nat'l Ctr. for Victims of Crime, Stalking Fact Sheet, (citing Judith McFarlane et al., 3 Homicide Studies 300-316 (1999).

Of the 25 cases the team has reviewed, the following red flags have been identified in multiple cases:

- 22 had a history of domestic violence
- 17 involved access to firearms
- 16 revealed separation or attempts to separate
- 16 included non-fatal strangulation
- 15 involved substance abuse
- 15 included threats of suicide/suicidal ideation
- 14 offenders had a criminal history in addition to DV
- 14 showed evidence of escalating violence
- 14 included the victim expressing fear
- 14 involved the offender breaking through doors/windows
- 12 revealed threats to kill

In more than half its cases, the team found instances of offenders breaking through doors or windows to reach, or try to reach, victims. The team has not seen this identified in other research as a lethality indicator, yet since it’s been present so often in the team’s cases it is being tracked as a red flag. The threatening message sent by such violation of physical boundaries is clear, and it leaves tangible evidence that can be documented by law enforcement.

[2] The team’s analysis is limited to what is in the records and what is learned from interviews, so it is possible other red flags exist that are unknown to the team in some cases.

Of the 25 cases reviewed the team has identified:

- 10 or more red flags in 11 cases
- 5-9 red flags in 11 cases
- 4 or fewer red flags in 3 cases
- Most red flags in a case: 17
- Fewest red flags in a case: 2

Prior Systems Contact

The team identifies the systems with which victims and/or offenders had contact before the homicide. Each contact with a system presents an opportunity for victims or offenders to receive assistance that could potentially lessen the risk of a lethal outcome. Understanding where these opportunities exist can be useful to communities as they think about outreach and screening.

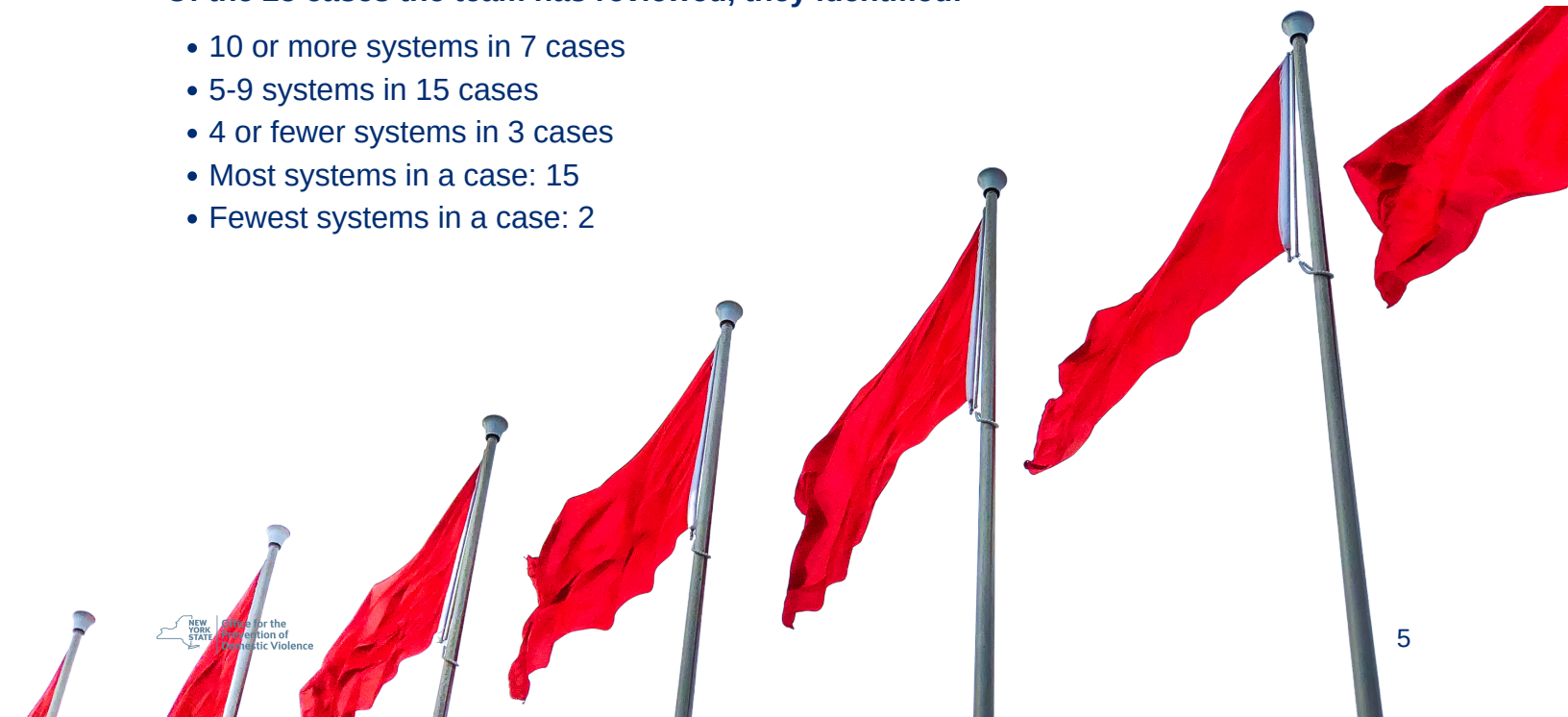
Of the 25 cases the team has reviewed:

- 23 had contact with law enforcement
- 21 had contact with the DA's office
- 20 had contact with the courts
- 16 had contact with the mental health system
- 10 had contact with probation
- 7 had contact with a domestic violence program

In addition to the formal systems above, the team notes informal systems involved in its cases. For example, in 21 cases, family and/or friends had some awareness of the domestic violence in the relationship and in 14 cases, there was some involvement with the victim and/or offender's workplace.

Of the 25 cases the team has reviewed, they identified:

- 10 or more systems in 7 cases
- 5-9 systems in 15 cases
- 4 or fewer systems in 3 cases
- Most systems in a case: 15
- Fewest systems in a case: 2



What the Team Has Learned

Through its review of cases and conversations with local responders, the team has learned about some tremendous work being done throughout the state, as well as the challenges communities experience in addressing domestic violence.

Communication

In addition to the strengths and challenges below, an overarching theme the team has seen in its reviews is the importance of communication. When working well, it can have a positive impact on response to cases, but when it does not happen at all, or is impeded in some way, it can create roadblocks that endanger victims and law enforcement. Communication between local responders, within and across jurisdictions, affects law enforcement response times, the ability of police and prosecutors to appropriately charge and monitor cases and victims' ability to make informed decisions and relevant safety plans.

In some cases reviewed, there were no clear jurisdictional boundaries for 911 which resulted in inconsistent local emergency response. In other cases, 911 communication was clear and efficient, resulting in quick response to situations involving individuals who might otherwise have been killed.

Strengths Identified in Cases Reviewed

- **Efforts of Responders**
  The cases reviewed by the team showed many examples of responders using all the tools they had to assist victims and enforce accountability, including:
  - Judges' thoughtful consideration of modifications of orders of protection
  - Police officers using an unmarked car when a victim feared the police being seen at her residence
  - Prosecutors regularly using jail calls to add charges in cases where offenders were contacting their victims in violation of orders of protection
- **Collaboration**
  Close working relationships among responders are important to reduce opportunities for cases to fall through the cracks. The team has learned about many successful collaborations happening in local communities, including:
  - Cross-training
  - Co-location of advocates in district attorneys' offices, police departments, social services departments, and courts
  - Active community coordination efforts, such as task forces
  - Intensive team approaches to domestic violence cases

- **Willingness to learn**
  While it can be daunting for communities to learn that the team is reviewing a local homicide case, the team has found local responders willing to share openly and honestly and learn anything possible to prevent similar outcomes in future cases.

In one community where the team reviewed a case, the District Attorney reported regular charging and prosecution of stalking in his county, while the team has seen low use of the stalking statutes in other communities. The DA credits this to the on-going training his office provides for police in charging and evidence collection in stalking cases.

Challenges Identified in Cases Reviewed

The challenges identified by the team are not unique to any one place. Similar issues have been seen multiple times in communities statewide. Challenges identified are also consistent with anecdotal information learned outside of fatality review.

While the challenges included in this report are not offered as the causes of the deaths or near-deaths reviewed, they do provide clarity about the many points in a case where interventions and supports could have been offered. Domestic violence cases are complex and the team's timelines show there are several points over the course of any case where interventions might have been made, services might have been offered or accountability might have been enforced. Fatality review helps make clear that no one event or action is solely responsible for the deaths or near-deaths in these cases, but each individual case can reveal opportunities to improve response to all cases.

- **Court Access**
  - **Victims not receiving a same day order of protection in Family Court**
    In some cases, victims who went to Family Court seeking an order of protection were not seen the same day, for a variety of reasons, but rather were asked to come back or given a date to return to Court.
  - **Responders not using local Criminal Courts to issue or modify Family Court orders of protection when Family Court is not in session**
    Per Criminal Procedure Law §530.12(3-a) & (3-b), local criminal court judges have the ability to issue or modify Family Court orders of protection when Family Court is not in session. This option was not used in any of the cases in which it could have been. Discussions with local responders indicate the option is not well-known and is used infrequently.

- **Inconsistent responses by court officers to violations of orders of protection in their presence**

  In some cases, offenders violated orders of protection while the parties were at court appearances. When made aware of the violations, court officers told the offenders to leave, rather than make an arrest.

In a homicide reviewed, an offender who had been abusing and stalking his ex-girlfriend followed her into a courthouse. The victim reported this to a court officer and explained that her ex-boyfriend was violating an order of protection. After the court officer told the offender to leave and come back another day, the offender waited outside the courthouse for the victim and then followed her.

- **Offender Accountability**
  - **Charging**

    In some cases, law enforcement officers did not charge certain crimes such as stalking, criminal contempt and felony strangulation, even when the facts supported those charges. Similarly, police often charged offenders with violations even when misdemeanor or felony charges were available.
  - **Conditional Discharges**

    In some cases, the team found that judges gave multiple adjournments in contemplation of dismissal and/or conditional discharges prior to the homicides. Even when offenders violated conditions, the original cases were not reopened.
  - **Mandatory Arrest/DIRs**

    In some cases, police responded to many domestic incidents prior to the homicide but there were few arrests, even when the mandatory arrest law would have applied. In several of these cases, the persons identified in the DIRs as the victim and the offender varied, and police did not appear to have tried to determine who was the primary physical aggressor.

In a homicide reviewed, there were 27 Domestic Incident Reports (DIRs) over a 16-month period. In another homicide reviewed, there were 45 DIRS over an eight-year period. In both cases, the individual most frequently identified by police as the victim ultimately stabbed and killed the person most frequently identified as the offender.

Informal Systems

- **Workplace**

  Several cases reviewed had some involvement with the victim and/or offender's workplace, including offenders contacting the victim at work or showing up at their workplace, coworkers being concerned about victims but not knowing how to help, and victims and offenders working at the same place.

In a homicide/suicide reviewed, the couple was divorcing. The husband frequently emailed and called his wife at her workplace, even though she asked him not to. He was also seen driving by her job even though he had no reason to be there.

The husband's profession required him to carry a firearm. In an email to him, his wife said she had been avoiding getting an order of protection because she didn't want to make problems for him with his job.

- **Family and Friends**

  In many cases, family members and other people in the victim's and offender's lives were aware of the domestic violence but didn't know how to respond. In addition, while they were concerned, they often did not think the offender would kill the victim.

  There was also inconsistency in the response to families and surviving children following the homicides reviewed. There was not a systematic way for families to receive information or direction, and the steps local responders took in the aftermath of the homicide regarding surviving children varied from place to place.

In 70-80% of intimate partner homicides, no matter which partner was killed, the man physically abused the woman before the murder.

Campbell, et al. (2003). "Assessing Risk Factors for Intimate Partner Homicide." Intimate Partner Homicide, NIJ Journal, 250, 14-19. Washington, D.C.: National Institute of Justice, U.S. Dept. of Justice.

- **Trauma/Mental Health**
  - **Many victims and offenders experienced early trauma in their lives**

    Many of the victims and offenders involved in the cases reviewed had experienced significant trauma in their lives, some from the time they were children.
  - **Lack of information when an individual enters the mental health system**

    In some cases, when individuals entered the mental health system, no information was available to those in other systems about what happened beyond that point. For example, when police brought individuals for a mental health evaluation, they were not told whether the person was admitted or released.

- **Lack of recognition that suicidal individuals may present risk to partner**
  In some cases, offenders were identified as at potential risk to commit suicide, but no one identified this as presenting a risk of homicide to their intimate partners.

In two homicides/suicides reviewed, family members said they'd tried for years to offer assistance to offenders they knew to be, or have been, suicidal. Following the homicide/suicides, these family members said they were not really surprised the offenders killed themselves, but they never imagined they would kill their intimate partners as well.

Fatality Review Implications

The findings of the fatality review team have provided learning which has, and will continue to, inform domestic violence policy and practice at the state-level, as well as provide direction for future work of the team. The steps already taken are having an impact on New York State's response to domestic violence. The issues identified present direction for the team's ongoing work to understand and address intimate partner homicide.

What Fatality Review is Teaching Us About Improving State and Local Response

The work of the fatality review team has highlighted areas communities and the State can work on to enhance the existing response to domestic violence, including:

- **Need for survivor-centered domestic violence services**, to increase connections between survivors and domestic violence programs
  - Meet survivors "where they are"
  - Provide range of options, including remote access to services
  - Focus on the creation of non-shelter options, while still maintaining strong access for those survivors who need shelter
- **Need for continued and enhanced training** for professionals who respond to domestic violence, including:
  - Mandatory arrest, primary aggressor and appropriate charging for police and prosecutors
  - Lethality assessment and trauma-informed response for all systems
  - Domestic violence dynamics training for systems such as mental health, substance abuse treatment, and private employers

Training efforts should include all responders within each entity and not only those in specialized domestic violence units or with domestic violence caseloads. The team found "general practitioners" handled as many, if not more, domestic violence incidents and cases than those who specialize in domestic violence.

- **Importance of strong collaboration** between entities that deal with domestic violence
  - Focus on enhancing existing collaborations to strengthen community coordination efforts
  - Expand collaborations to include new systems, such as:
    - Business/workplace
    - Suicide prevention
    - Housing
  - Examine ways to create and implement community-based accountability strategies
- **Importance of awareness and information for victims and public**
  - Use of social media to reach broad range of population with information about domestic violence, lethality/danger indicators, how to be an ally
  - Focus on police as a resource to provide information and connect victims to services, since law enforcement is the most-accessed system in the cases reviewed
  - Publicize use of hotlines as resources for friends and family who want to be allies to someone about whom they are concerned
  - Create community-specific response plans for dealing with domestic homicides, including connecting victims' families to local service providers in the aftermath of the homicide and responding to the needs of surviving children, including establishing safety and security for children immediately following the homicide as well as providing trauma-informed counseling and other supportive services in the years that follow

Many children of intimate partner homicide never receive therapy, delay getting help, or see a professional only once.

Armour, M., International Perspectives in Victimology 5 (2011) 2, 22-32.

- **Need for improved information sharing** between responders, particularly police and other criminal justice responders, such as prosecutors and probation officers, including the use of existing tools for information sharing:
  - NYS DIR Repository
  - Crime Analysis Centers
  - Arrest Alerts
  - NYS Order of Protection Registry[3]

[3] The NYS Family Protection Registry is a database of active and expired orders of protection. Criminal justice users can access the Registry via the eJustice portal.

Steps Taken

Because the fatality review team includes state policy makers whose agencies are tasked with addressing different aspects of New York State's response to domestic violence, the findings of the team are continually being incorporated into new and existing efforts. Several important steps have already been made within the State based, at least in part, on the work of the fatality review team, including:

- Order of protection training for town and village judges
- Training for Office of Court Administration personnel regarding firearms and orders of protection
- Partnership between OPDV and the NYS Department of Health to address non-fatal strangulation
- Adoption by probation departments throughout the State of a specialized domestic violence screening instrument, the DVSI-R, with training and support from NYS Division of Criminal Justice Services Office of Probation and Correctional Alternatives
- OPDV public awareness efforts, including:
  - Red Flag (lethality indicators) pocket card
  - Strangulation brochure
  - Enhanced social media presence
- Inclusion of lethality indicator questions on the NYS Domestic Incident Report form
- OPDV local assistance funding for addressing high-danger domestic violence cases by creating enhanced services for high-risk victims and enhanced accountability for high-danger offenders

Victims of non-fatal strangulation are seven times more likely to be killed by their intimate partner in the future.

Non-fatal strangulation is an important risk factor for homicide of women
Nancy Glass et al.. J Emerg Med. Author manuscript; available in PMC 2009 Oct 1.

The Work Ahead

OPDV and its partner agencies will continue to incorporate learning from fatality review into efforts to enhance statewide domestic violence policy and practice by focusing, among other things, on addressing some of the following issues:

- **Examining how the ongoing COVID-19 pandemic affects safety for victims** and how the team's learning can be used to inform efforts to address domestic violence within the context of the pandemic
- **Continuing to incorporate information** about services available to domestic violence victims, what bystanders can do if they suspect a loved one is a victim of domestic violence, and red flags that might indicate increased lethality risk for victims into new and ongoing public awareness efforts

- **Examining ways for New York State to more proactively assure safe access** to courts for victims of domestic violence, including strategies such as:
  - Providing safety information to victims regarding potentially increased risk upon issuance of orders of protection
  - Providing guidance for the creation of protocols for issuance and modifications of Family Court orders of protection when Family Court is not in session
  - Increased access to remote requests for orders of protection
  - Training for court officers regarding violations of orders of protection and steps to be taken in response, and other domestic violence issues
- **Examining how to work more effectively** with private employers to increase understanding of domestic violence, its impacts within the workplace, and steps that may be taken to assist victims
- **Examining ways to continue to improve** law enforcement understanding of, and response to, domestic violence, given that police may be the first system to have contact with victims in many cases
  - Training
  - Policies
  - Improve access to information and communication
  - Engage closely in coordinated community response efforts
- **Examining ways to use what is being learned** to make mental health providers more aware of the connections between threats of suicide by domestic violence offenders and homicide/suicides committed by those offenders
- **Examining the role of the community** in creating and implementing accountability measures for those who commit domestic violence, including how and when community-based responses might be used in addition to existing criminal justice-based accountability responses.
- **Examining ways for New York State to address the ongoing trauma** experienced by children who lose one or both parents to intimate partner homicide, as well as guidance on developing coordinated community response plans for responding to domestic homicide

Conclusion

The team recognizes that every case that contributed to the information in this report represents tragic loss of life, lasting trauma for families, and ripples that reverberate through communities. As difficult as these cases are, learning from them is important. The team remains committed to the review of domestic violence deaths and near-deaths going forward, and to sharing more of what is learned to help communities and the State do everything possible to reduce domestic homicides.

OPDV and its partner agencies are available to work with communities to apply the learning of the fatality review team to their local response to domestic violence. To learn more about the assistance available, or to refer a case for possible review, please contact the New York State Fatality Review Team: opdvfatalityreview@opdv.ny.gov

Appendix A

NYS Domestic Violence Fatality Review Team Cases Reviewed

Note: Cases are not in the order they were reviewed

CASE VARIABLES		CASES																								
		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y
Gender Victim:	Female	X	X	X	X	X		X	X		X	X	X	X	X		X		X	X	X	X	X		X	X
	Male						X			X						X		X						X		
Gender Offender:	Female						X			X						X	X							X		
	Male	X	X	X	X	X		X	X		X	X	X	X	X			X	X	X	X	X	X		X	X
Age Victim:	Under 20				X																					
	20-39			X			X	X	X		X				X		X	X	X	X		X	X	X		X
	40-59		X			X						X	X	X		X					X				X	
	60 and above	X								X																
Age Offender:	Under 20																									
	20-39		X		X		X	X	X	X	X				X		X	X	X	X		X	X	X		X
	40-59			X		X						X	X	X		X									X	
	60 and above	X																			X					
Race/Ethnicity Victim:	White	X		X	X		X	X	X	X	X	X	X		X					X			X		X	X
	Black		X			X										X	X	X	X			X				
	Asian													X												
	Hispanic																				X			X		
Race/Ethnicity Offender:	White	X			X		X	X	X		X	X	X							X		X	X		X	X
	Black		X	X		X				X					X	X	X	X	X					X		
	Asian													X												
	Hispanic																				X					
Relationship:	Spouse/ex-spouse	X	X									X	X	X							X				X	
	Intimate partner			X	X	X	X	X	X	X	X				X	X	X	X	X	X		X	X	X		X
Weapons Used:	Blunt object/hands, fists	X			X										X					X		X				
	Knife/cutting instrument	X							X	X		X			X	X	X	X						X	X	
	Firearm		X	X		X	X	X			X		X	X					X		X		X*			X
	Other																									
Offender Suicide/Killed:			X	X		X		X			X		X	X							X		X			X
Children Present:						X		X	X			X		X										X		
Children/Third Parties Killed:						X							X	X												

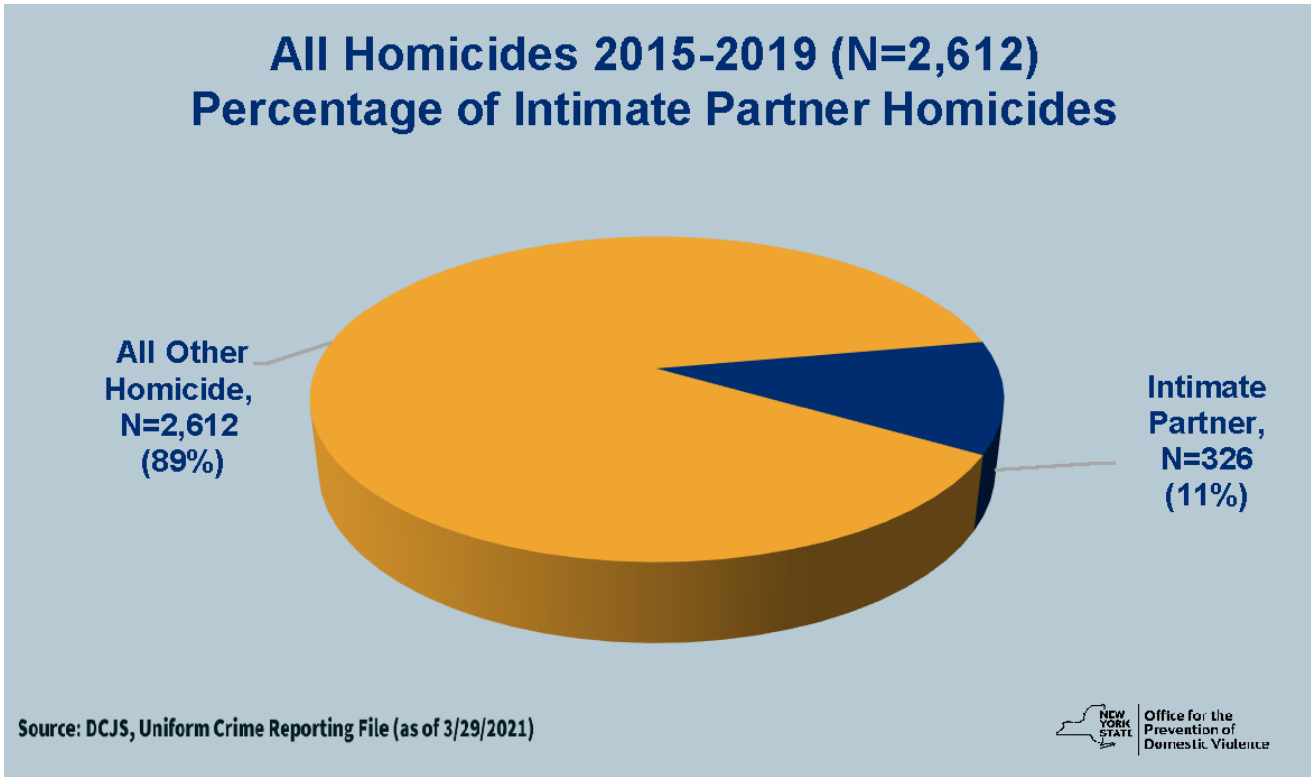
Red indicates near-death

*Victim threatened with a firearm

APPENDIX B

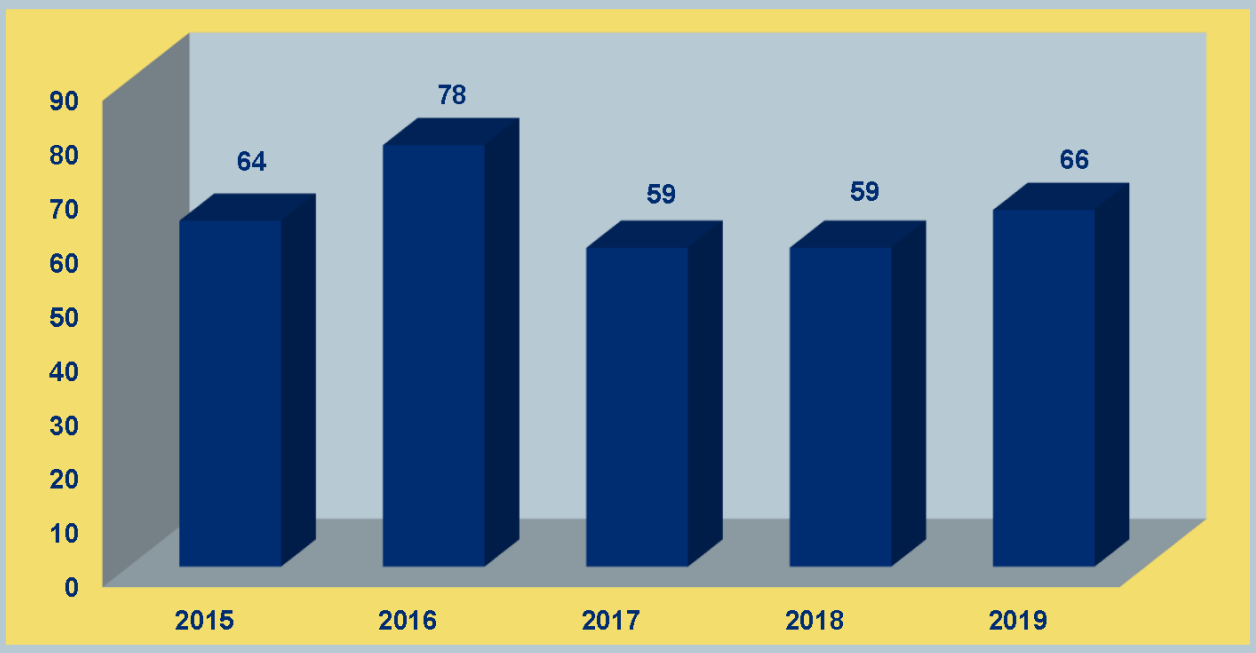
Overview of Intimate Partner Homicide in New York State [4]

The information presented in this section provides an overview of intimate partner [5] homicide in New York State for a five-year period: 2015 – 2019.[6] The NYS Division of Criminal Justice Services (DCJS) publishes annual domestic homicide reports that provide comprehensive statewide information about domestic and intimate partner homicide in New York State, from which the information compiled below is taken. Readers should refer to the full reports for more detailed information.



[4] Percentages in this section may not total 100 due to rounding.
[5] For the purposes of this report, "intimate partner" is defined as a current of former spouse or dating partner.
[6] The data analyzed for this report are taken from the Supplementary Homicide Report (SHR) submitted by law enforcement to DCJS. Part of New York State's Uniform Crime Reporting program (UCR), the SHR collects case-level information on all criminal homicides reported by police, including victim-offender relationship, demographic characteristics of victim and offender (gender, race/ethnicity and age), as well as the circumstances of the homicide and type of weapon used.

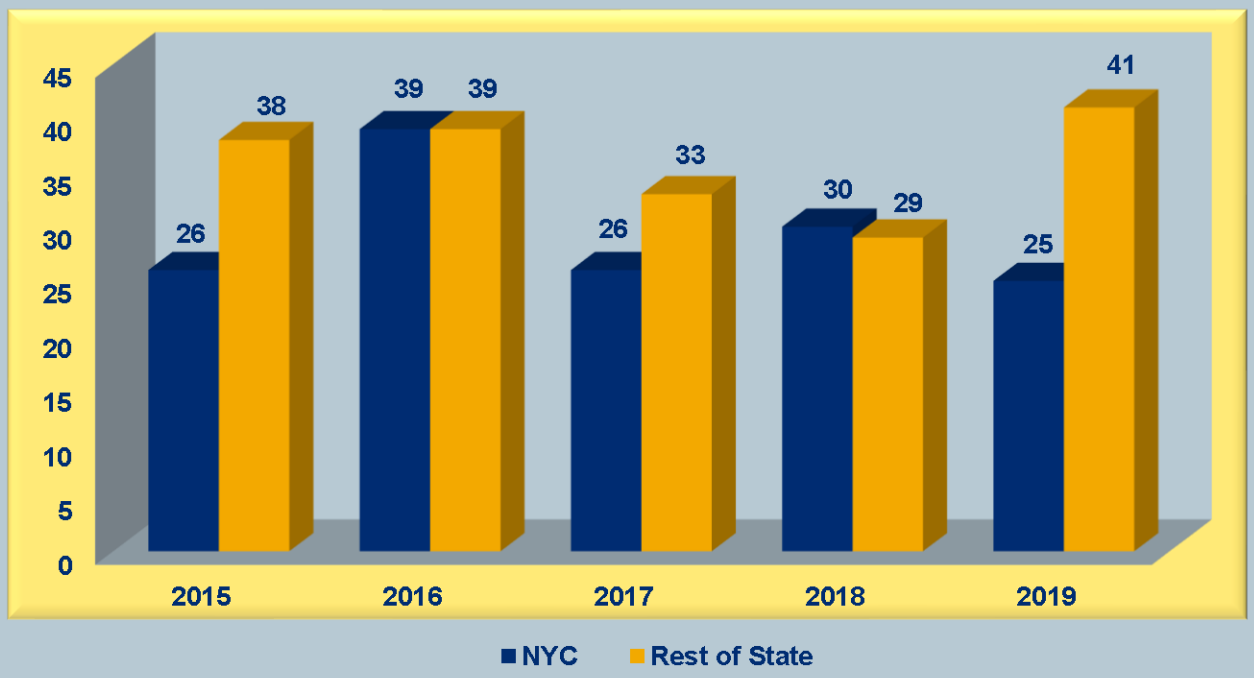
Intimate Parter Homicides: Statewide 2015-2019



Source: DCJS, Uniform Crime Reporting File (as of 3/29/2021)

NEW YORK STATE | Office for the Prevention of Domestic Violence

Intimate Partner Homicides: NYC vs. Rest of State, 2015-2019



Source: DCJS, Uniform Crime Reporting File (as of 3/29/2021)

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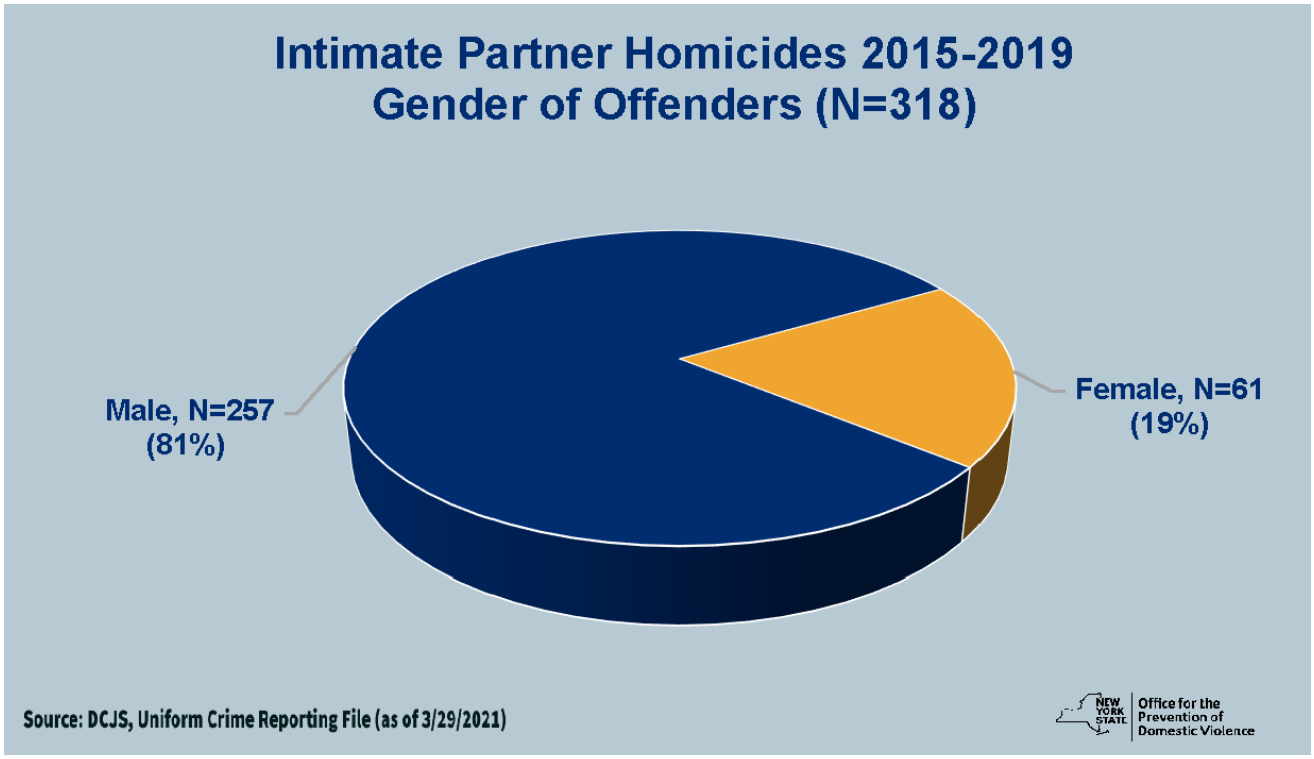
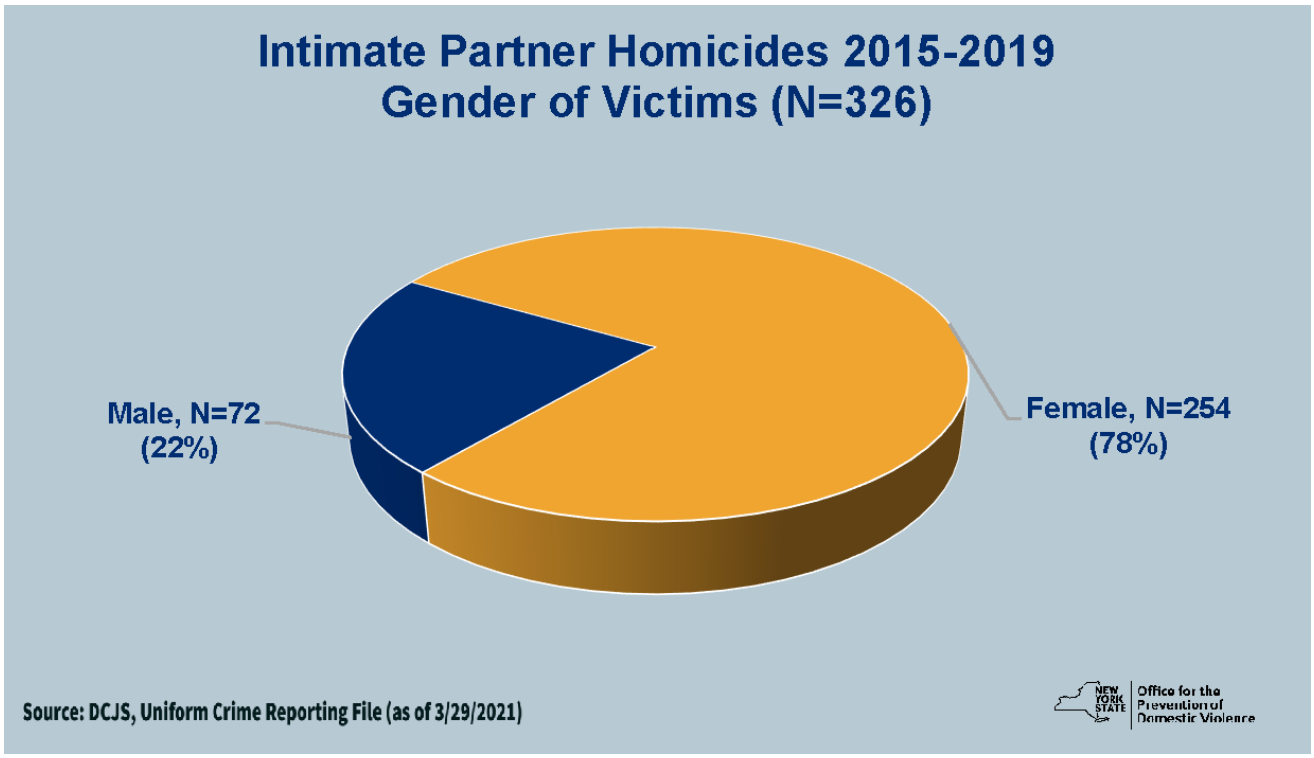
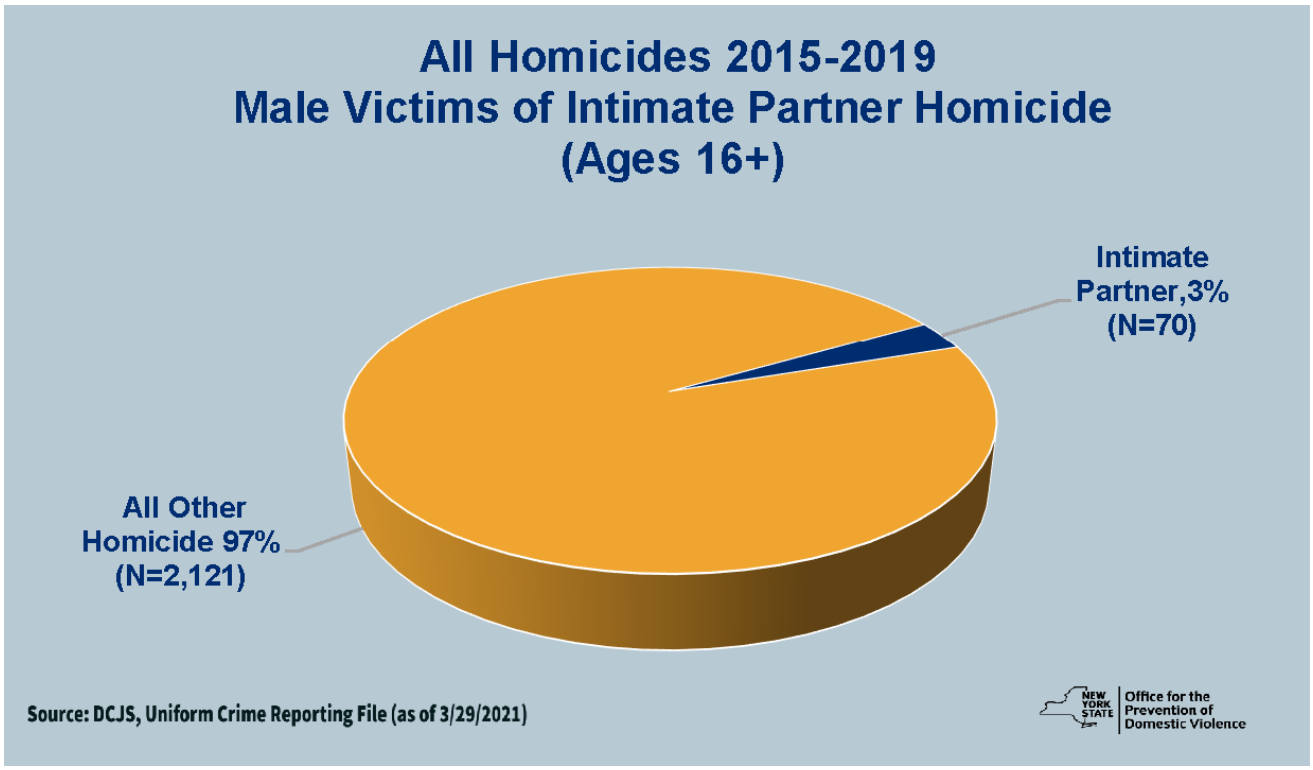


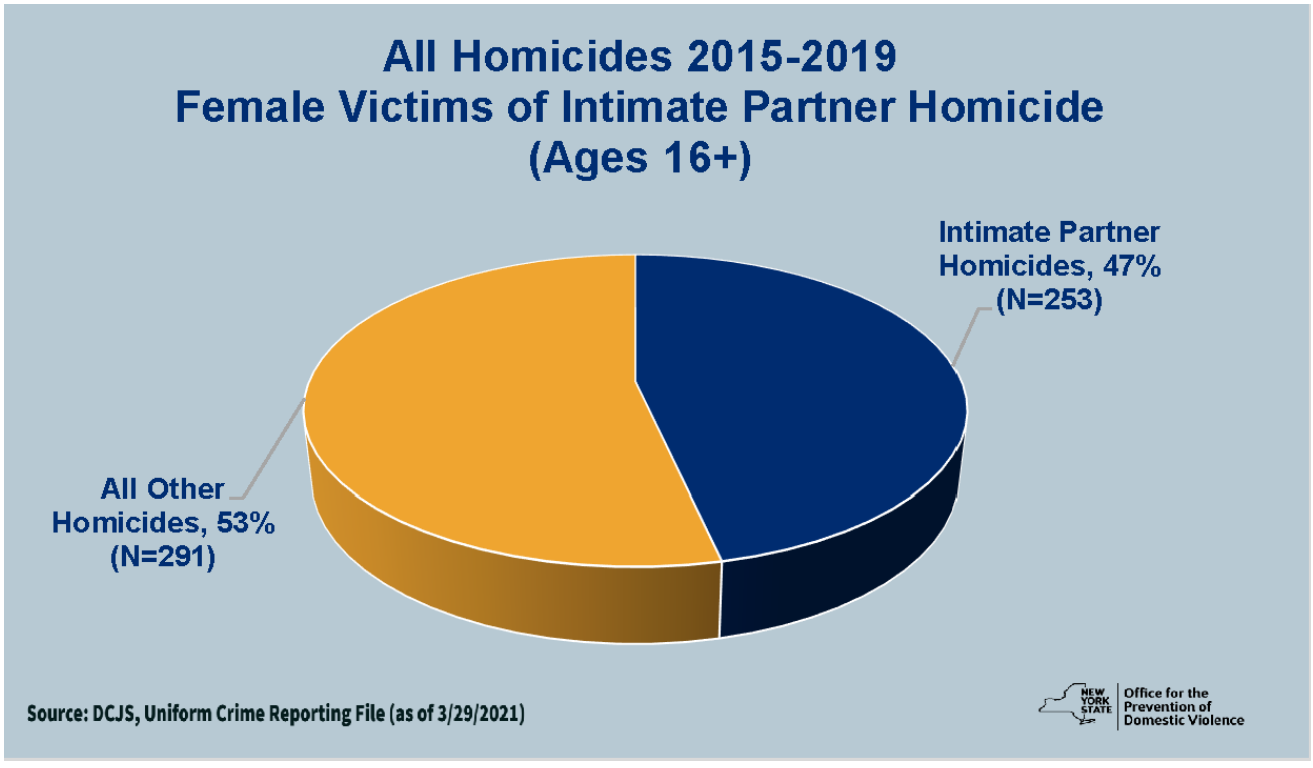
Gender of Victims and Offenders[7]

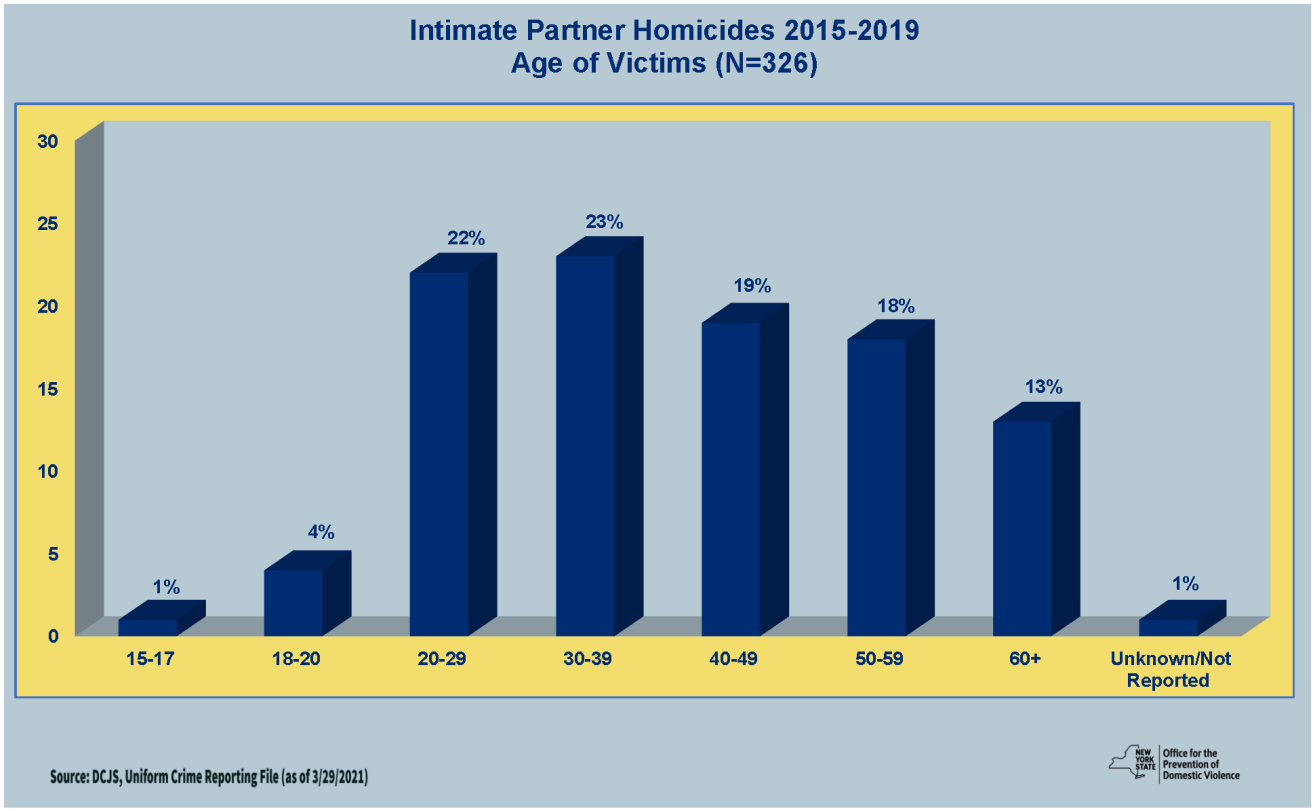


[7] For the period of 2015 – 2019, there were more intimate partner homicide victims than offenders. This is due to a small number of reported incidents where a single offender killed two people, both coded as their intimate partner.

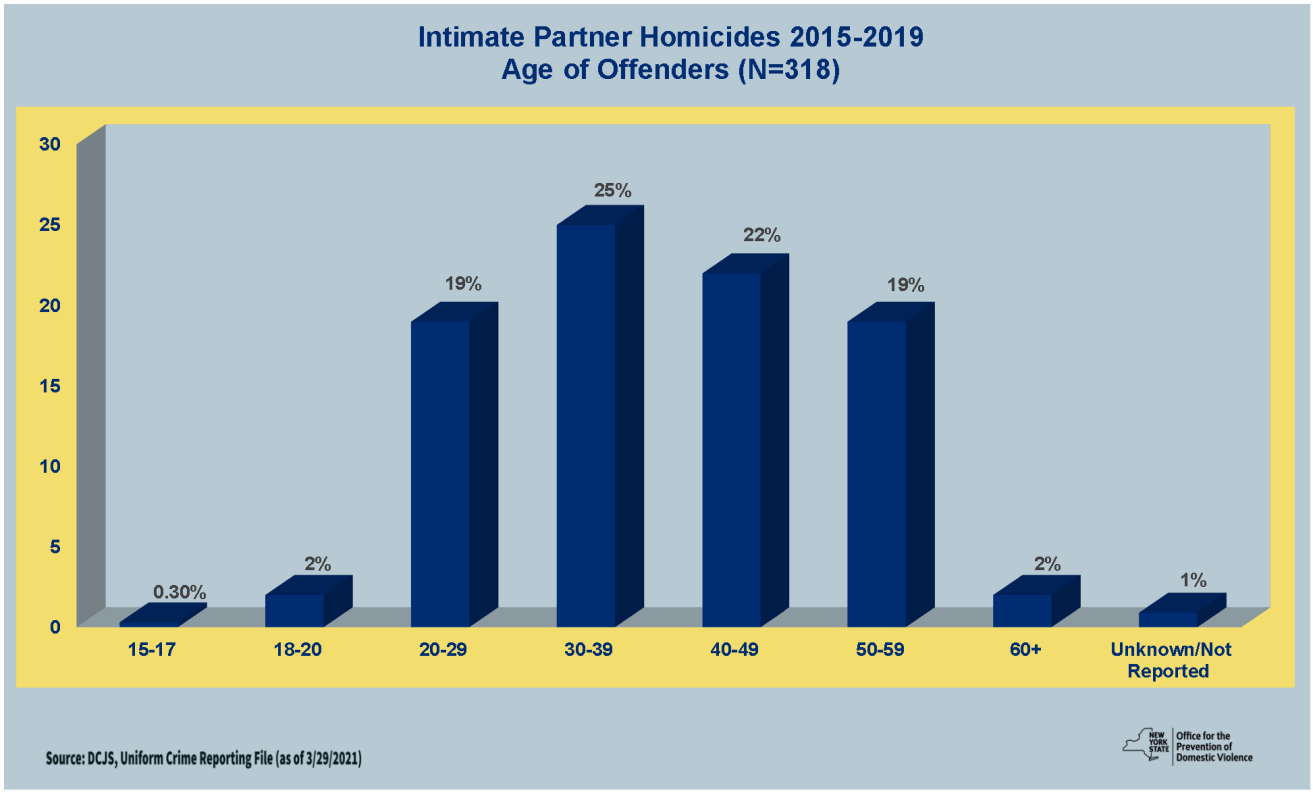


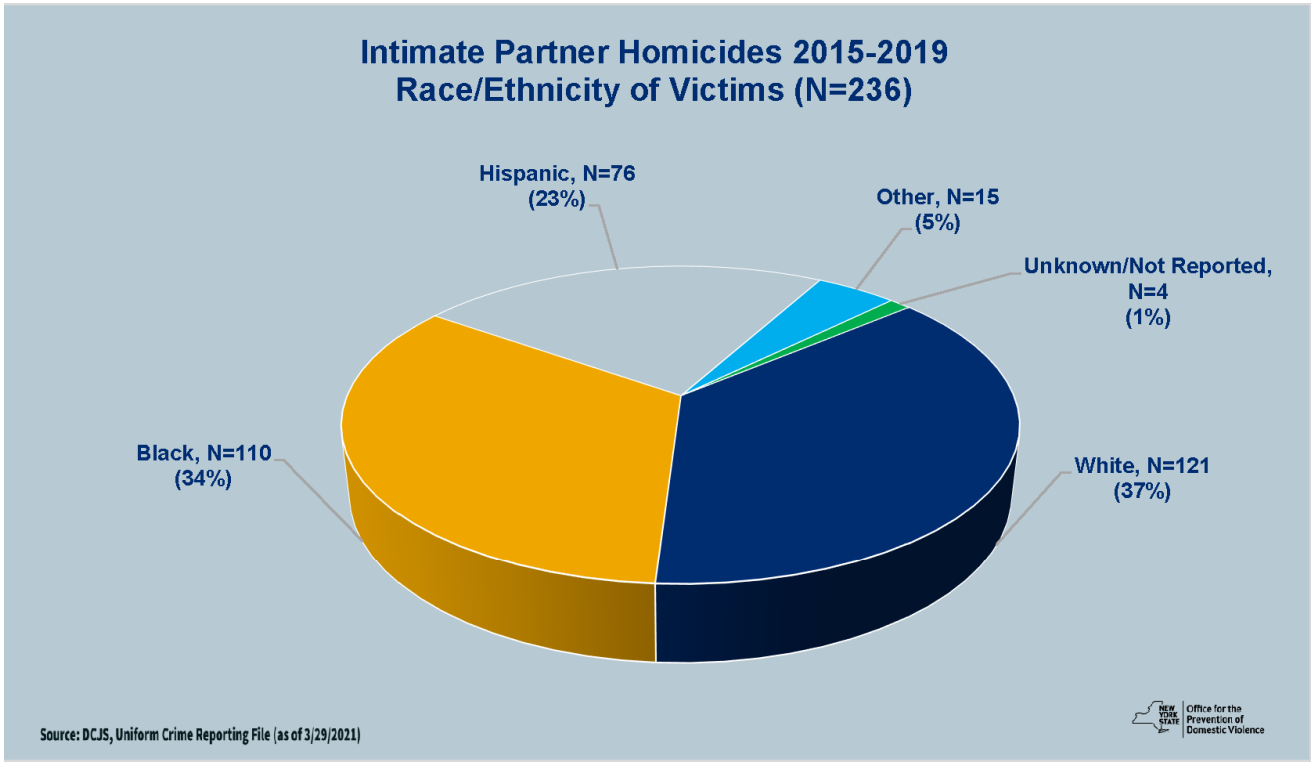
Intimate Partner Homicide Victims by Gender



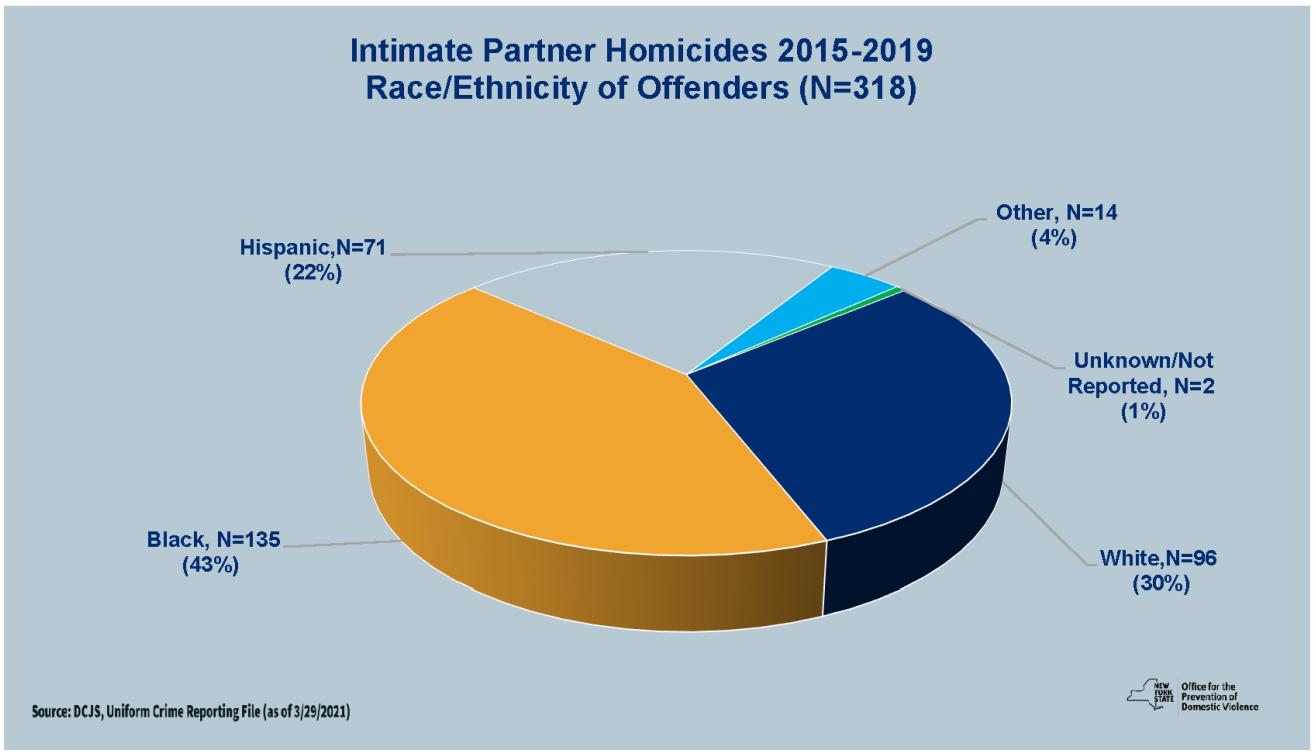


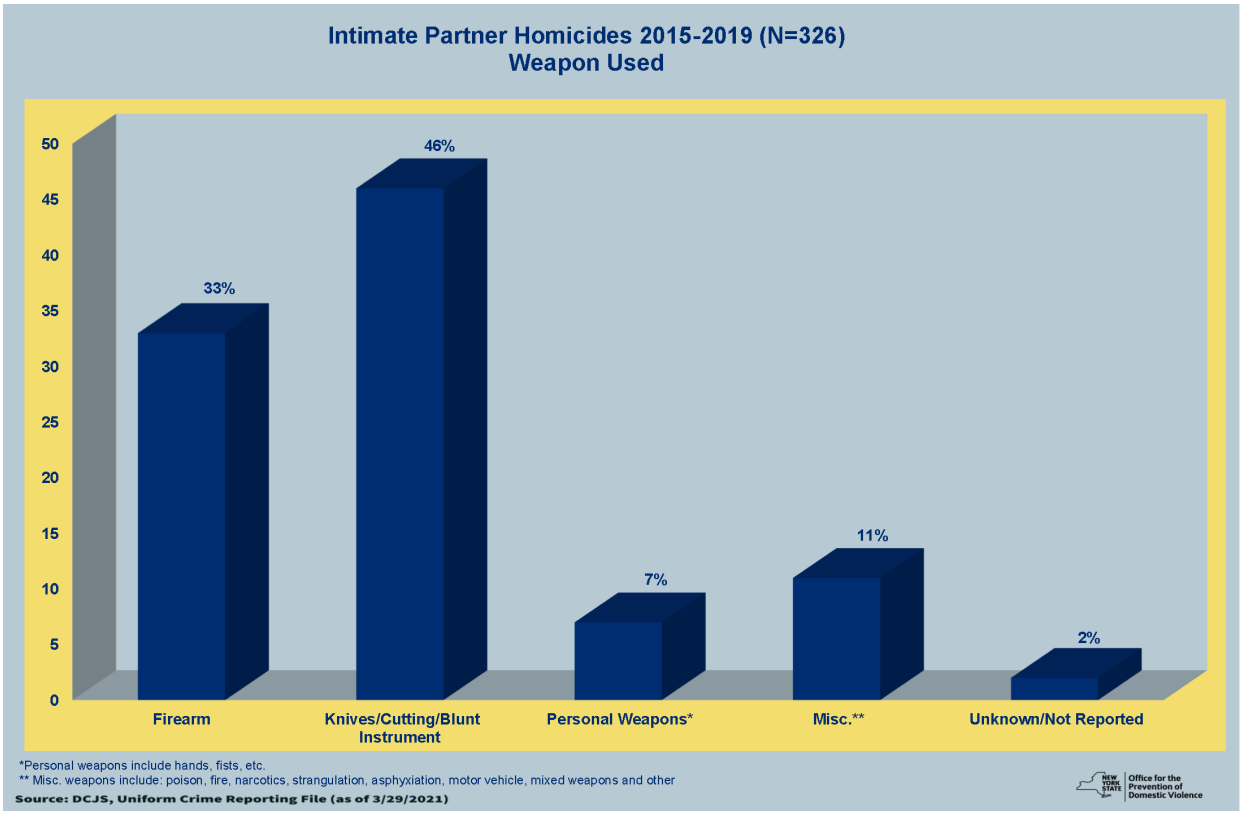
Age of Victims and Offenders





Race/Ethnicity of Victims and Offenders





Weapon Usage