

Philadelphia Women's Death Review Team

Analysis of Deaths Among Philadelphia Women Ages 15 through 60

2004 - 2006

Including a Review of Trends, 1997- 2006

December 2008

*A project of the Philadelphia Department of Public Health,
The Philadelphia District Attorney's Office, The Public Health
Management Corporation and Women in Transition*

Authors

Members of the Philadelphia Women's Death Review, Core Leadership Team, provided significant editorial contributions:

Philadelphia Department of Public Health,
Division of Maternal, Child and Family
Health

Ugo Chizea-Abuah
Marjorie Angert
Adina Ekwerike
Kate Maus
M. Patricia West

Philadelphia District Attorney's Office

Francesca Criniti

Public Health Management Corporation

Michelle Henry and Jennifer Keith

Women in Transition

Roberta Hacker

For information about the Philadelphia Women's Death Review, contact:

<p>Adina M. Ekwerike, MPH Health Program Manager Philadelphia Interdisciplinary Mortality Review Division of Maternal, Child and Family Health Philadelphia Department of Public Health 1101 Market Street, 9th Floor Philadelphia, PA 19107 Phone: (215) 685-5259 Email - adina.ekwerike@phila.gov</p>	<p>Ugo Chizea-Abuah, MSPH PIMR Coordinator Philadelphia Interdisciplinary Mortality Review Division of Maternal, Child and Family Health Philadelphia Department of Public Health 1101 Market Street, 9th Floor Philadelphia, PA 19107 Phone: (215) 685-5234 Email: ugo.chizea-abuah@phila.gov</p>
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Acknowledgments

We wish to acknowledge the work and dedication of the individual members of the Philadelphia Women's Death Review Team (PWDRT), representing numerous city agencies, hospitals and community-based organizations, who have served throughout the process that led to this final report.

A special thanks to the Philadelphia Department of Public Health and the Division of Maternal, Child and Family Health, especially Donald F. Schwarz, MD, MPH, Deputy Mayor, Health and Opportunity and Health Commissioner, Nan Feyler, Chief of Staff, Katherine C. Maus, ACSW, LSW, Director, Division of Maternal, Child and Family Health, and Sam P. Gulino, MD, Chief Medical Examiner, City of Philadelphia Medical Examiner's Office, as well as Lynne Abraham, District Attorney for the City of Philadelphia and her staff for their continued support of the Philadelphia Women's Death Review Team. The work of the Team could not have been possible without additional assistance provided by the Philadelphia Department of Public Health, Division of Information and Reimbursement Systems, the Health Data, Statistics and Research Office of the Health Commissioner, as well as the Pennsylvania Department of Health, Division of Health Statistics, which provided the 1997 through 2006 vital statistics of women 15 through 60 to the Philadelphia Department of Public Health.

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Chapter 1. Executive Summary

I. Background and Introduction

The Philadelphia Women's Death Review Team (PWDRT) was founded in 1996 to identify violence against women as a critical public health issue, and to acknowledge and address the devastating physical and emotional consequences of such violence on women, children and families. PWDRT is the first locally based, multidisciplinary, interdisciplinary review in Pennsylvania. Core leadership is provided by the public-private partnership of the Philadelphia Department of Health, the Philadelphia District Attorney's Office, the Public Health Management Corporation and Women in Transition.

The central objectives for the review include: (1) Tracking the incidence and prevalence of violence-related deaths of women; (2) Identifying the degree to which intimate partner violence (IPV) contributes to the community's mortality; (3) Identifying patterns and trends in violence-related deaths of women; and (4) Formulating key policy and practice recommendations to improve the systems that serve and protect women and their children.

Based on the selection criteria, the cases reviewed include homicide, suicide, and undetermined cause, death due to adverse drug reactions, drug or alcohol-related natural death (e.g., cirrhosis of the liver) death to a woman within a year of giving birth (pregnancy-associated), AIDS or HIV-related disease (e.g., atypical mycobacterium), death with questionable circumstances, and death with an inadequate death certificate.

Between 1997 and 2006, the PWDRT systematically reviewed 3,159 premature deaths of Philadelphia women ages 15-60; accounting for a review of 22 percent of all deaths to Philadelphia women ages 15-60 between 1997 and 2006. According to the electronic City File 14,614 Philadelphia, women between 15 and 60 have died between 1997 and 2006.

Key Recommendations

PWDRT identified 10 key recommendation areas. The Team believes these recommendations highlight the greatest needs and have the most potential to reduce trauma and premature death for women and children in Philadelphia. PWDRT's key recommendations are:

1. Safer Street – Safer Homes

- a. Develop a citywide DV prevention program encouraging neighbor-to-neighbor networking to reduce isolation and promote community vitality.
- b. Develop protocols within the Police Department for immediate referrals of children who have experienced the death of a parent or witnessed a traumatic event to trauma assistance services.
- c. Promote outreach in schools, community and family centers, and faith-based organizations for children who witness violence.

2. Family Court

- a. Develop a program to co-locate DV counselors from the advocacy community at the PFA filing unit.
- b. Develop procedures that accomplish victim safety and intimidation reduction in the court process.

3. Perpetrator Accountability

- a. Increase the availability of intervention services for abusers.

4. Weapons-Related Mortality

- a. Promote legislation to decrease gun access, such as efforts to legislate "one gun a month" purchasing restrictions.

5. Professional Training and Education

- a. Expand capacity in prioritizing coordinated training programs for professionals in the fields of mental health, child welfare, education, health, homelessness and public housing systems regarding the impact of trauma, DV and substance abuse on women.

6. Law Enforcement

- a. Expand the work of the Victim/Witness Task Force to expand training of first-hand responders for immediate and automatic referrals of children under age 18 who witness a traumatic event.
- b. Centralize the DV and Special Victims Units within the Police Department to ensure that: (1) victims and perpetrators are not lost as they move from one district to another, and (2) there is standardization and oversight of police response to DV calls including how calls are coded.

7. Resource Development

- a. Expand capacity of crisis treatment centers for children and youth to provide appropriate trauma intervention and treatment to children
- b. Expand literacy levels for all materials developed for use at court and in agencies.
- c. Encourage collaboration efforts between the Department of Human Services and the Department of Behavioral Health by providing access to addiction specialists and substance abuse treatment resources for DHS worker.

8. Probation and Parole

- a. Implement a comprehensive training program for Probation/Parole staff on issues including DV, post-traumatic stress disorder, sex worker issues, and women and addiction.
- b. Develop a pilot collaboration between probation officers and the Philadelphia Police Department regarding off-hours visits to high-risk DV probationers.
- c. Establish a task force in the Mayor's Office of Offender Re-Entry Services to better serve the needs of the female offender population and their children.

9. Coordinated Data to Limit and Prevent Further Violence

- a. Develop an integrated data management systems and protocol among Family Court, Criminal Court, law enforcement agencies, Adult Probation and Parole Department and the Department of Human Services. A data system is expected to improve coordination of services and identify cases at high risk for violence (i.e., cases where there have been frequent PFA petitions and child custody actions), as well as to specify when multiple systems are involved with a family.
- b. Recommend Medical Examiner's Office protocol to conduct rape kits for all homicides and undetermined deaths of women where violence is suspected and subject those swabs to DNA analysis. This will enable the Police Department tracking of those persons to identify possible witnesses or perpetrators, and possible serial perpetrators.

10. Pregnancy Associated Deaths

- a. Implement routine screening of every pregnant woman for IPV at the first prenatal visit, once in each trimester and postpartum visit, and routine OB/GYN or preconception visits.

II. Definitions

Domestic violence (DV) consists of behaviors, physical, sexual and emotional, used in any relationship to gain or maintain control (National Domestic Violence Hotline, 2005b). DV includes not only violence in intimate partner relationships of spousal, live-in partners and dating relationships, but also includes familial, elder and child abuse present in a home (National Coalition Against Domestic Violence, 2005).

Protection From Abuse Orders (PFA) - In Philadelphia, a PFA prohibits one person from having contact with another, such as in cases of DV or witness intimidation. Under the Protection from Abuse Act, individuals have the right to go to court and ask a judge for a protection from abuse order (often called a PFA order) forcing your abuser to leave you alone. The court order may include any of the following:

- Stopping the abuser from further acts of abuse;
- Evicting the abuser from your household;
- Keeping the abuser from going to your home, school, or job;
- Giving you or the other parent temporary custody of, or temporary visitation, with your child or children.

PFA's are issued by Philadelphia Family Court, and direct the defendant/abuser to refrain from abusing, threatening, harassing, or stalking the plaintiff; to stay away from the plaintiff's home (even if it is also the defendant's residence), work, or school; and to turn weapons over to the police. PFA's can be issued for up to 18 months, and are available to anyone abused by a current or former spouse, a parent, a child, a current or former sexual or intimate partner (including both heterosexual and homosexual partners), and others related by blood or marriage (Women's Law Project, 2005).

Intimate partner violence (IPV) is the abuse that occurs between two people in a close relationship. The term "intimate partner" includes current and former spouses and dating partners. IPV exists along a continuum from a single episode of violence to ongoing battering (CDC: Fact Sheet, 2006)¹.

¹ There is no one agreed upon definition of DV or IPV. These terms are often used interchangeably.

III. Data Highlights: 2004 – 2006 (N=529)

Homicide

- PWDRT identified and reviewed 83 homicide cases among Philadelphia women (Ages 15-60), which occurred between 2004 and 2006.
- PWDRT found that intimate partner violence (IPV) was the most frequent known circumstance of all homicide cases at 25 percent (n=21). Thirty-two (39 percent) of the homicide victims had a known history of DV.

Intimate Partner Violence Deaths

- PWDRT identified and reviewed 32 intimate partner homicides occurring between 2004 and 2006. In Philadelphia during these years, intimate partner homicide accounted for 39 percent of all the homicides to women ages 15-60.
- The majority of these women were Black (81 percent, n=25).

Firearm-Related Deaths

- Between 2004 and 2006, 54 deaths reviewed by PWDRT were a result of a firearm-related death (40 homicides, nine suicides, three undetermined and two accident deaths).
- Firearm deaths represent ten percent of violence-associated deaths reviewed by PWDRT between 2004 and 2006.

Drug and/or Alcohol-Related Deaths

- Forty-two percent (n=223) of the violence associated deaths among Philadelphia women between 2004 and 2006 were related to drugs and/or alcohol.
- The majority of these women (62 percent, n=139) had a known history of substance abuse.
- Twenty-seven percent (n=61) of these women had a known history of DV.

AIDS/HIV Related Deaths

- PWDRT reviewed 62 HIV/AIDS-related deaths occurring between 2004 and 2006.
- Thirty-two percent (n=20) of decedents who were HIV-positive or who had AIDS also had a known history of DV.

Commercial Sex Work

- Twelve percent of the decedents reviewed by PWDRT who died between 2004 and 2006 had a known history of prostitution (n=66).

Homelessness

- PWDRT identified 38 decedents who were known to the Office of Supportive Housing (OSH).
- The majority of these women were Black (61 percent, n=23) and non-Hispanic (94%), and their average age was 40 years.
- Forty-two percent (n=16) of women with a history of homelessness had a known history of DV.

Mental Health

- Twenty-six percent of the decedents reviewed by the PWDRT between 2004 and 2006 (n=138) had a history of diagnosis and/or treatment for a mental health condition.
- Twenty-three percent of the women reviewed in 2004 and 2006 with a known mental health treatment/diagnosis history had a known history of DV.

Pregnancy-Associated Deaths

- PWDRT identified and reviewed the pregnancy-related/associated deaths of 29 Philadelphia women who died between 2004 and 2006.
- Overall, 28 percent of the women who were either pregnant at the time of their death or died within a year of giving birth (n=8) had a known history of DV.

Children

- Of the 529 women who died between 2004 and 2006, at least 476 children had a mother that was reviewed by PWDRT who died a violence-related death.
- PWDRT identified with certainty at least 18 children who either witnessed the deaths of their mother, or found her body between 2004 and 2006. More than one-half of these cases involved a homicide (n=15).

IV. Data Highlights: 1997-2006 (N=3159)***Homicide***

- PWDRT reviewed the cases of 358 Philadelphia women who died as a result of homicide between 1997 and 2006.
- More than one in four homicide victims had a known history of DV (31%, n=110).

Intimate Partner Violence Deaths

- Intimate partner homicides accounted for 40 percent of all homicides between 1997 and 2006. Averages of 14 women per year (n=140) were killed between 1997 through 2006 due to IPV.
- The number and rates of intimate partner homicides of women in Philadelphia have declined between 1997 and 2005 until a slight increase in 2006.

Firearm-Related Deaths

- Between 1997 and 2006, 241 deaths reviewed by PWDRT involved firearms (including 185 homicides, 49 suicides, five undetermined deaths and two accident deaths).
- Firearm deaths represent eight percent of violence-associated deaths reviewed by PWDRT since 1997.

Drug and/or Alcohol-Related Deaths

- Forty-one percent (n=1,281) of the violence-associated deaths among Philadelphia women between 1997 and 2006 were related to drugs and/or alcohol.
- Twelve percent (n=155) had a known history of DV.

AIDS/HIV Related Deaths

- PWDRT reviewed 611 HIV/AIDS-related deaths (18 percent) among Philadelphia women that occurred between 1997 and 2006.
- Ten percent of these women (n=62) had a known history of DV.

Commercial Sex Work

- From 1997 through 2006, 11 percent of the decedents reviewed by PWDRT had a known history of prostitution (n=341).

Homelessness

- One hundred and fifty-three women reviewed by PWDRT were either currently homeless or had a history of homelessness prior to their deaths.

Mental Health

- Over 600 of the decedents (20 percent) reviewed by the PWDRT between 1997 and 2006 had a history of diagnosis and/or treatment for a mental health condition (n=639).
- Nineteen percent of these women (n=124) had a known history of DV at the time of their death.

Pregnancy-Associated Deaths

- PWDRT identified and reviewed the pregnancy-associated deaths of 119 Philadelphia women who died between 1997 and 2006.
- Two-thirds of the women were Black (68 percent, n=81), 27 were White (23 percent), four (3 percent) were Asian, and eight were of other or unknown race (6%).
- Overall, 15 percent of the women who were either pregnant at the time of their death or died within a year of giving birth (n=18) had a known history of DV.

Children

- Between 1997 and 2006, at least 2,011 children, under the age of 18, lost their mother to a violence-associated death.

V. Key Recommendations:

PWDRT has identified ten key recommendation areas out of the many that appear in this report (see Policy Recommendations chapter for more information, page 69). The Team believes these ten recommendations highlight the greatest needs and have the most potential to reduce trauma and premature death for women and children in Philadelphia. However, each recommendation in this report is relevant to violence in the lives of women and their children and our ability as a community to prevent violence. Many of these recommendations originally were made in the 1997-2003 report. PWDRT believe that some previous recommendations are still pertinent and current progresses are highlighted through this section. PWDRT's key recommendations are:

1. Safer Street – Safer Homes
 - a. Develop a citywide DV prevention program with the Mayor's leadership encouraging neighbor-to-neighbor networking to reduce isolation and promote community vitality.
 - b. Develop a protocol within the Police Department to automatically refer all children who have experienced the death of a parent or witnessed a traumatic event to trauma assistance services.
 - c. Promote outreach in schools, community and family centers, and faith-based organizations for children who witness violence.
2. Family Court
 - a. Develop a program to co-locate DV counselors from the advocacy community at the PFA filing unit, so that safety planning and empowerment counseling are available for all individuals petitioning for protection from abuse. This program should include provision of follow-up and outreach for cases, which are dismissed for failure to prosecute.
 - b. Develop procedures that accomplish victim safety and intimidation reduction in the court process by adopting a written protocol through the Family Court Administrative Judge to enable court accompaniment by community advocates and support networks to reduce intimidation and ensure safety in the court process.

Progress: Currently, a pilot project is in operation involving Philadelphia Legal Assistance, Women's Law Project & Women Against Abuse Legal Center with Drexel law students who are providing information and referral.

3. Perpetrator Accountability
 - a. Increase the availability of intervention services for abusers by engaging those service providers already working with this population (Menergy, Men's Resource Center) to develop partnerships or additional resources through linkages with community groups (Men United for a Better Philadelphia and fatherhood initiatives) and city agencies such as men's drug treatment centers, mental health providers and prison programs.
4. Weapons-Related Mortality
 - a. Promote legislation to decrease gun access, such as efforts to legislate "one gun a month" purchasing restrictions.

Progress: A citywide Weapons-Related Injuries Surveillance System (WRISS) has been implemented to capture all weapons-related injuries (i.e., guns, knives, bats, fists) and develop interventions driven by this data. The Pennsylvania Injury Reporting and Intervention System in Philadelphia provides intensive case management for youth ages 15-24 who have been admitted to three local hospitals for gunshot wounds.

5. Professional Training and Education

- a. Expand capacity in prioritizing coordinated training programs for professionals in the fields of mental health, child welfare, education, health, homelessness and public housing systems regarding the impact of trauma, DV and substance abuse on women.

Progress: Lutheran Settlement House has a specific training program targeting professional service providers, which is currently being conducted bi-monthly; Women in Transition, Inc., Women Against Abuse, Congreso de Latinos Unidos, and Women Organized Against Rape also provide a similar variety of such trainings.

6. Law Enforcement

- a. Expand the work of the Victim/Witness Task Force to expand training of first-hand responders for immediate and automatic referrals of children under age 18 who witness a traumatic event. Services should include counseling/mental health and crisis treatment services within 36 hours.
- b. Centralize the DV and Special Victims Units within the Police Department to ensure that: (1) victims and perpetrators are not lost as they move from one district to another; (2) there is standardization and oversight of police response to DV calls including how calls are coded.

7. Resource Development

- a. Expand capacity of crisis treatment centers for children and youth to provide appropriate trauma intervention and treatment to children under the age of five and above the age of fourteen because they remain underserved age groups.
- b. Expand literacy levels for all materials developed for use at court and in agencies, by developing educational resources that are both cultural and literacy appropriate to address to needs of families being served.
- c. Encourage collaboration efforts between the Department of Human Services and the Department of Behavioral Health by providing access to addiction specialists and substance abuse treatment resources for DHS workers to assist in assessing families in which there are possible substance abuse problems.
- d. Increase the awareness of the DV White Ribbon Campaign; an emerging program focused on getting more men involved in speaking out against DV against women.

8. Probation and Parole

- a. Implement a comprehensive training program for Probation/Parole staff on issues including: DV; post-traumatic stress disorder; sex worker issues; and women and addiction.
- b. Develop a pilot collaboration between probation officers and the Philadelphia Police Department regarding off-hours visits to high-risk DV probationers
- c. Establish a task force in the Mayor's Office of Offender Re-Entry Services to investigate how the City can better serve the needs of the female offender population and their children to make steps in breaking the cycle of violence, addiction, crime and premature death.

9. Coordinated Data to Limit and Prevent Further Violence

- a. Develop an integrated information system and protocol among Family Court, Criminal Court and law enforcement agencies to identify cases at high risk for violence (i.e., cases where there has been frequent PFA petitions and child custody actions).
- b. Continue to support the integration of data management systems for Philadelphia Adult Probation and Parole Department and the Department of Human Services to improve coordination of services.

- c. Continue to support the refinement and implementation of a citywide social service system (such as Cares) so that agencies can identify when multiple systems are involved with a family.
 - d. Recommend that the Medical Examiner's Office develop a protocol to conduct rape kits for all homicides and undetermined deaths of women where violence is suspected and subject those swabs to DNA analysis. This will enable the Police Department to track those persons who may have been the last person to have been with this woman when she was still alive, to identify possible witnesses or perpetrators, and to identify possible serial perpetrators.
10. Pregnancy Associated Deaths
- a. Implement routine screening of every pregnant woman for intimate partner violence at the first prenatal visit, at least once in each trimester and at the postpartum visits, and at routine OB/GYN visits and preconception visits

Chapter 2. Introduction and Methodology

I. Introduction

Violence against women represents a critical public health problem that continues to have devastating consequences for men, women and their families, as well as the communities in which they reside. According to (CDC: Fact Sheet, 2006) intimate partner violence (IPV)² can be a crime against both men and women, as documented by the following national statistics, but does disproportionately affect women:

- In 2005, more than 1,110 women and 330 men died as a result of IPV. That same year, CDC's Behavioral Risk Factor Surveillance collected data from more than 70,000 adults and reported 26.4 percent of women and 15.9 percent of men were victims of physical or sexual IPV primary during their lifetime (DELTA Program).
- “Nearly 5.3 million intimate partner victimizations occur among U.S. women, ages 18 and older, annually. This violence results in nearly 2.0 million injuries and nearly 1,300 deaths” (CDC, 2004).
- In 2003, Rennison reported that, “The National Crime Victimization Survey found that 85 percent of intimate partner violence victims were women” (CDC, 2005).
- In 2003, The Bureau of Justice Statistics reported that on average more than three women are murdered by their husbands or boyfriends everyday in the United States (National Domestic Violence Hotline, 2005a).
- In 2001, The Federal Bureau of Investigation estimated that nearly an intimate partner (CDC, 2004a) kills one-third of female homicide victims reported to the police.

In the United States, research infrastructure to support IPV prevention efforts has been built in the form of fatality reviews. There are currently 28 states that review and analyze deaths due to intimate partner violence, the circumstances leading to the deaths, breaches in service delivery, and then use this information to improve prevention strategies (Websdale, 2003). Toward this end, the Philadelphia Women's Death Review Team (PWDRT) represents the first multi-agency, interdisciplinary effort in Philadelphia County designed to prevent future, violence-related deaths to Philadelphia women between the ages of 15 and 60.

Unlike other DV fatality review teams in the United States, PWDRT looks beyond intimate partner violence against women to include other violence-associated causes of death that have deadly consequences. Substance abuse, HIV/AIDS, homelessness and suicide are frequently associated with violent lives (Websdale, 2003). Therefore, examining multiple factors associated with violence can enhance our understanding of violence against women, its prevention and opportunities for intervention (CDC, 2005). By taking this broader perspective, PWDRT hopes to develop, prevention strategies that address not only women at risk of homicide, but also those also affected by substance abuse, HIV/AIDS, homelessness and behavioral health disorders.

² Intimate Partner Violence - refers to abuse that occurs between two people in a close relationship. The term “intimate partner” includes current and former spouses and dating partners. IPV exists along a continuum from a single episode of violence to ongoing battering.

The actual review of violence-associated deaths occurs through a three-step process: (1) review of individual deaths, (2) analysis of aggregate data, and (3) the development of recommendations for corrective and proactive action. The Team includes representatives from government agencies, law enforcement, courts, hospitals, DV service and advocacy groups, and other community agencies. Since the Team's inception in 1997, many agencies have contributed to the PWDRT data gathering process. These member agencies are critical partners to the PWDRT.

2004-2006 Review Team Member Agencies

<ul style="list-style-type: none"> ▪ Anti-Violence Partnership of Philadelphia <ul style="list-style-type: none"> ▫ Families of Murder Victims 	<ul style="list-style-type: none"> ▪ Philadelphia Family Court <ul style="list-style-type: none"> ▫ Adult Probation and Parole Department ▫ Family Court Division – DV Unit
<ul style="list-style-type: none"> ▪ Children's Crisis Treatment Center <ul style="list-style-type: none"> ▫ Trauma Assistance Program 	<ul style="list-style-type: none"> ▪ Philadelphia Department of Human Services <ul style="list-style-type: none"> ▫ Children and Youth Division
<ul style="list-style-type: none"> ▪ Congreso de Latinos Unidos, Inc. 	<ul style="list-style-type: none"> ▪ Philadelphia Department of Public Health <ul style="list-style-type: none"> ▫ The Division of Maternal, Child and Family Health ▫ Public Health Consultant
<ul style="list-style-type: none"> ▪ Philadelphia's District Attorney Office 	<ul style="list-style-type: none"> ▪ Public Health Management Corporation <ul style="list-style-type: none"> ▫ Research and Evaluation
<ul style="list-style-type: none"> ▪ Drexel University School of Public Health 	<ul style="list-style-type: none"> ▪ Philadelphia Legal Assistance
<ul style="list-style-type: none"> ▪ Federal Bureau of Investigation 	<ul style="list-style-type: none"> ▪ Philadelphia Police Department <ul style="list-style-type: none"> ▫ Homicide Unit ▫ Special Victims Unit
<ul style="list-style-type: none"> ▪ Grief Assistance Program, Inc. 	<ul style="list-style-type: none"> ▪ Temple University School of Medicine
<ul style="list-style-type: none"> ▪ Lutheran Settlement House <ul style="list-style-type: none"> ▫ Bilingual DV Project 	<ul style="list-style-type: none"> ▪ Women Against Abuse
<ul style="list-style-type: none"> ▪ Office of Emergency Shelter and Services 	<ul style="list-style-type: none"> ▪ Women In Transition
<ul style="list-style-type: none"> ▪ Medical Examiner's Office 	<ul style="list-style-type: none"> ▪ Women Organized Against Rape
<ul style="list-style-type: none"> ▪ Philadelphia Department of Behavioral Health/Mental Retardation Services <ul style="list-style-type: none"> ▫ Community Behavioral Health ▫ Office of Mental Health 	<ul style="list-style-type: none"> ▪ Women's Law Project

II. Methodology

The Philadelphia Women's Death Review Team is comprised of four interdependent components: Core Leadership Committee, Clinical Screening Committee, Review Team, and Policy Committee. Each component is responsible for a specific aspect of collecting, sharing, and discussing information regarding any history of reported violence or other factors known about a woman's death, which may indicate that domestic or intimate partner violence was a factor in her life.

PWDRT reviews deaths of women aged 15-60 years who were residents³ of Philadelphia County at the time of their deaths. Deaths are identified through the following three sources:

- 1) Death Certificate (Appendix D) information is provided by the Division of Information and Reimbursement Systems of the Philadelphia Department of Public Health in the form of paper death certificates and a compact disk with the Electronic City File of deaths⁴;
- 2) Medical Examiner Files located at the Philadelphia Office of the Medical Examiner; and
- 3) Review of media reports.

Death certificate data are stored in a secure database and in a locked file located at MCFH. All deaths are reviewed retrospectively, approximately one year after the date of death. This method of retrospective review allows PWDRT to obtain the most complete information available and usually ensures that active investigations and open cases within the criminal justice system are complete by the time of PWDRT review.

Team Composition and Activities

The Core Leadership Committee, which includes designated representatives from the Philadelphia Department of Public Health, provides team leadership Philadelphia District Attorney's Office, the Public Health Management Corporation (PHMC) and Women In Transition. The Core Leadership Committee meets regularly to discuss the direction of PWDRT, establish agendas, determine Review Team membership, and monitor project activities including program development and fiscal management.

The Clinical Screening Committee is comprised of representatives from public health, human services, medicine, law enforcement, and victim's services, and meets monthly at the Medical Examiner's Office to review all death certificates of Philadelphia female residents ages 15-60. Between 2005 and 2007, the committee examined (2004-2006) death certificates for adequacy of information, and determined which cases should be reviewed by the Review Team. Deaths from the following categories were reviewed:

³ Methodology changed in late 2007, for the review of 2006 cases as the definition of "Philadelphia resident" was defined as a person who resides in Philadelphia at time of death.

⁴ The City gets death certificate information on a disk from the Pennsylvania State Division of Health Statistics. The data on the disk are the primary source of death certificate information. PWDRT uses the City certificates for filing, to fill in missing data in the fatality database housed at MCFH, and to bring to the monthly review meetings. PWDRT uses the State certificates; only a paper City certificate is missing.

- (1) homicide⁵,
- (2) suicide,
- (3) undetermined manner of death⁶,
- (4) drug or alcohol-related natural death (e.g., cirrhosis of the liver),
- (5) AIDS or HIV-related disease (e.g., atypical mycobacterium),
- (6) death due to adverse drug reactions,
- (7) death to women known to be within a year of giving birth or pregnant at time of death (pregnancy-related),
- (8) death with questionable circumstances, and
- (9) inadequate death certificate

Based on the work of this committee, a list of cases to be reviewed were distributed to members of the Review Team two weeks prior to the monthly review meeting, thus allowing Team members time to gather case-specific information from their agencies.

The Review Team met monthly in a confidential and collaborative forum to systematically review deaths selected by the Clinical Screening Committee. The Review Team members include individuals from government, non-government and community agencies working in the areas of law, health, advocacy and social service (Appendix A). Representatives from the participating agencies share confidential information regarding any agency contact and/or interaction with the women or their children prior to their deaths. This information also includes the completeness of the death investigation by the appropriate agencies, and, in cases of homicide, the response of the law enforcement and judicial communities. In addition, when available, information is collected about the perpetrator(s) involved in the homicide cases. Each case is then carefully reviewed to identify what role, if any, domestic or intimate partner violence played in the life and death of each woman. In cases where there was a known history of violence, and in cases where an intimate partner murdered the decedent, the Review Team identifies the policies, laws, regulations, system changes, and/or services that, if implemented, might have prevented the deaths of these women. The Team uses the data and the experience of its members to formulate key policy and practice recommendations with the long-term goal of improving the systems that serve and protect women and their children.

The Policy Committee met periodically to continue discussions on issues that came up during monthly case review meetings, to review DV policies and death prevention strategies, and, as appropriate, to create subcommittees that work to refine PWDRT's recommendations. Additionally, the Policy Committee examines issues related to the coordination of local violence intervention and treatment systems. All PWDRT members are invited to participate in Policy Committee meetings. Invitations are further extended to elected representatives, academic institutions, agency administrators, and community advocacy groups.

Case Selection Criteria for 2004 Deaths

Because of reduced funding to the PWDRT, the Team's Core Leaders (Philadelphia Department of Public Health, Philadelphia District Attorney's Office, and Women in Transition) made a strategic decision to change the operating methodology of the Team for the 2005 calendar year. Subsequently, the Team

⁵ Unlike the Uniform Crime Report's definition of "murder" (the unlawful killing of a human being with malice afterthought), "homicide" is defined as any death by the hands of another, regardless of whether charges are brought (e.g. self-defense) but does not include vehicular manslaughter (Federal Bureau of Investigation, 2004).

⁶ Deaths are certified as undetermined when serious doubt exists as to the cause and manner of death. Information concerning the circumstances may be lacking because of insufficient background information, lack of witnesses, or because of a lengthy delay between death and discovery of the body. If an extensive investigation and autopsy cannot clarify the circumstances, the death is placed in this category.

decided to reduce data entry, analysis and reporting requirements, which led to a significant reduction in the number of violence-associated deaths of women (ages 15-60) reviewed. A reduction in cases provided more in-depth discussions of individual cases, as well as more in-depth discussion of policy recommendations at each meeting. Case selection criteria for 2004 deaths reflected an effort to review approximately 60 cases in 2005. A selection of cases with manners of death related to suicide, drug/alcohol (including long-term abuse), HIV/AIDS, and accident deaths were added to monthly lists for possible review, as funds permitted.

Team members brought information for all cases to each meeting, and at the beginning of the meeting would indicate for which of the possible cases they had available information. This action selected only sample possible cases for review. The selection was based on the quantity and quality of information available from agencies for each case. The new case selection criteria for Philadelphia women with date of death in 2004 were:

Cases for Definite Review	Cases for Possible Review
<ol style="list-style-type: none"> 1. All Homicides 2. All Undetermined deaths 3. All Maternal Mortality deaths (pregnancy-associated) 	<ol style="list-style-type: none"> 1. Suicides 2. Drug/Alcohol related (including long term D/A abuse) deaths 3. HIV/AIDS deaths 4. Unintentional Injury deaths

From the “Cases for Possible Review” category, subsets of cases were selected based on the amount of information available to the team at the time of review meeting. At the review meeting it was determined which cases were known to the greatest number of agencies and were to be reviewed. The cases not chosen were not reviewed, but were filed for possible review in the future, should resources allow.

Case Selection Criteria for 2005 Deaths

From January 2006 through June 30, 2006, the team applied the 2004 case definition as described above to review deaths among women that occurred in 2005. Beginning July 1, 2006, the management of the Philadelphia Women’s Death Review Team was transitioned from the Public Health Management Corporation to the Philadelphia Department of Public Health, Division of Maternal, Child and Family Health (MCFH). MCFH took responsibility for the management, data-related activities, administrative and bureaucratic responsibilities of the Team, including maintenance, review, security, and storage of death certificates. The transition also allowed a resumption of reviewing all violence-associated deaths along with selected cases of natural deaths of women 15-60 years old.

The mid-year change in case selection criteria that expanded case selection criteria began in July 2006. Case changes to the selection criteria for 2005 deaths allowed the Team to review 136 cases. The selection was based on the quantity and quality of information available from agencies for each case. The new case selection criteria for Philadelphia women with date of death in 2005 were:

1. All Homicides
2. All Undetermined deaths
3. All Maternal Mortality deaths (pregnancy-associated)
4. Selected Suicides
5. All Unintentional Injury deaths
6. All Drug/Alcohol related (including long term D/A abuse) deaths
7. Selected HIV/AIDS deaths
8. Selected Natural deaths as determined by clinical screening committee

Case Selection Criteria for 2006 Deaths

In addition to reviewing all violence-associated deaths that occurred in 2006, PWDRT expanded its focus to include a broader maternal mortality review to better address issues of women's health before, during, and after pregnancy. Across the United States, "pregnant and recently pregnant women are more likely to be victims of homicide than to die of any other cause, and evidence exists that a significant proportion of all female homicide victims are killed by their intimate partners" (Frye, 2001). Further, "research suggests that injury related deaths, including homicide and suicide, account for approximately one-third of all maternal mortality cases, while medical reasons make up the rest. However, homicide remained the leading cause of death overall for pregnant women, followed by cancer, acute and chronic respiratory conditions, motor vehicle collisions and drug overdose, peripartum and postpartum cardiomyopathy, and suicide" (Nannini, Weiss, Goldstein, & Fogerty, 2002).

The selection criteria for review included: homicides, suicides, undetermined manner, drug or alcohol-related natural deaths, AIDS/HIV-related diseases, death due to adverse drug reactions, deaths of women within a year of giving birth, deaths with questionable circumstances and inadequate death certificates.

Confidentiality

The review process undertaken by PWDRT requires the sharing of confidential case information. Accordingly, PWDRT has implemented measures to protect the privacy of the study population as well as the work of the Review Team participants. All Team members are required to sign a confidentiality statement prior to participating in the review process (Appendix B). Continued participation is contingent upon compliance with the terms of the confidentiality statement. The confidentiality statement prohibits unauthorized dissemination of information beyond the purpose of review, and prohibits PWDRT members from creating any files with specific case-identifying information. Outside of review meetings, only aggregate PWDRT data is shared.

Data Collection and Data Management

The information that is shared at both the Clinical Screening Committee meetings and the Review Team meetings is recorded on a data form that was developed by PWDRT (Appendix C). PWDRT collects data on the victim's contact with agencies and the circumstances surrounding the death as well as information on her children and/or the perpetrator when applicable. PHMC staff entered 2004 and part of 2005 data information into a secure, computerized database located at PHMC. The original data forms are kept in a secure, locked file cabinet at all times. This process was transferred to MCFH in July 2006.

Data forms are periodically adjusted to reflect new or refined variables of interest and changes in data collection methods among the agencies of Team members. Due to this adjustment, not all variables are available from 1997 to 2003. In this report, current variables were used whenever possible to examine data, as far back as it were available.

Description of the Population

According to the 2000 Census, Philadelphia had a population of 1.52 million. This number includes 493,969 women between the ages of 15 and 60. From 2005 to 2007, the Clinical Screening Committee reviewed all deaths of Philadelphia women between 15 and 60 years that occurred in 2004, through 2006 (N=4,137). Based on the selection criteria previously described, PWDRT selected 529 of the 4,137

deaths for full review (Table 1). Not every violence-associated death was reviewed, as noted in case selection review criteria.

Table 1: Deaths of Philadelphia Women (Ages 15-60) by Manner of Death and Reason for Review, 2004 – 2006

Manner of Death and Reason for Review	Number of Deaths	Deaths Selected for Review*
Natural	3,438	194
<i>AIDS/HIV</i>		62
<i>Long-term D/A Abuse</i>		66
<i>Questionable Circumstances</i>		24
<i>Pregnancy-Associated</i>		7
<i>Other</i>		35
Accident	400	167
<i>Long-term D/A Abuse</i>		23
<i>Adverse Effects of Drugs</i>		118
<i>Questionable Circumstances</i>		15
<i>Other</i>		11
Homicide	86	83
Suicide	68	40
<i>Suicide</i>		39
<i>Pregnancy-Associated</i>		1
Undetermined Cause	58	45
<i>Long-term D/A Abuse</i>		3
<i>Adverse Effects of Drugs</i>		13
<i>Questionable Circumstances</i>		28
<i>Pregnancy-Associated</i>		1
TOTAL	4050	529

Source: Philadelphia Electronic Vital Statistic 2004 - 2006, Philadelphia Department of Public Health and PWDRT data

*Note that reasons for review may sum to a total greater than the number of cases reviewed as a case might have been selected for multiple reasons. Note total does not include “pending” and cases for which manner of death was not provided so total may be less than number of total deceased. Two women were selected for review because the Clinical Screening Committee and the Review Team determined that they were residents of Philadelphia, although this was not recorded on their death certificates. Residency was discussed at the Review meeting, and if a woman lived unofficially with a relative or partner in Philadelphia (not on a lease or public record, but spent most or all of her time at the residence), she was included in review as an official resident.

This report also summarizes findings and trend data, as well as geographic data from 10 years of PWDRT data, 1997 through 2006. PWDRT has reviewed the deaths of 3,159 Philadelphia women dying during this time. **At the time of this report all reference to 2006 Philadelphia Vital Statistics Report numbers are preliminary data.** (Table 2)

Table 2: PWDRT Reviewed Deaths of Philadelphia Women (Ages 15-60) by Manner of Death, 1997-2006⁷

Manner of Death (N=3159)							
	Natural	Accident	Suicide	Homicide	Undetermined	Unknown*	TOTAL by year
Year							
1997	211	121	30	47	21	0	430
1998	148	81	29	48	4	3	313
1999	218	77	21	35	16	0	367
2000	208	124	29	35	13	7	416
2001	191	123	30	35	10	4	393
2002	211	101	28	31	21	1	393
2003	156	76	29	44	13	0	318
2004	21	22	7	28	16	0	94
2005	33	54	16	19	14	0	136
2006	140	91	17	36	15	0	299
TOTAL	1537	870	236	358	143	15	3159

Source: PWDRT data, 1997 – 2006.

*Between 1997 and 2006 there were 12 deaths to women ages 15-60 that were reported as pending and three manners of death that were unknown. Numbers provided in this table represent only the cases reviewed by PWDRT and should not be confused with Vital Statistics numbers.

Missing Data

When reviewing deaths, some data are missing because information is not available to Team members or information cannot be accessed. It is common for women who have had an episode(s) of violence in their lives to never meet health, social, or law enforcement agencies. There are many reasons why a woman would remain unknown to these agencies, including fear, lack of knowledge or access, shame, and depression. Because of this, PWDRT is unable to have complete data on all the cases reviewed due to the under-reporting of violence in general and, specifically, in the lives of those who die. It is most likely that the incidence of violence in the lives of Philadelphia women who die prematurely described here is underreported.

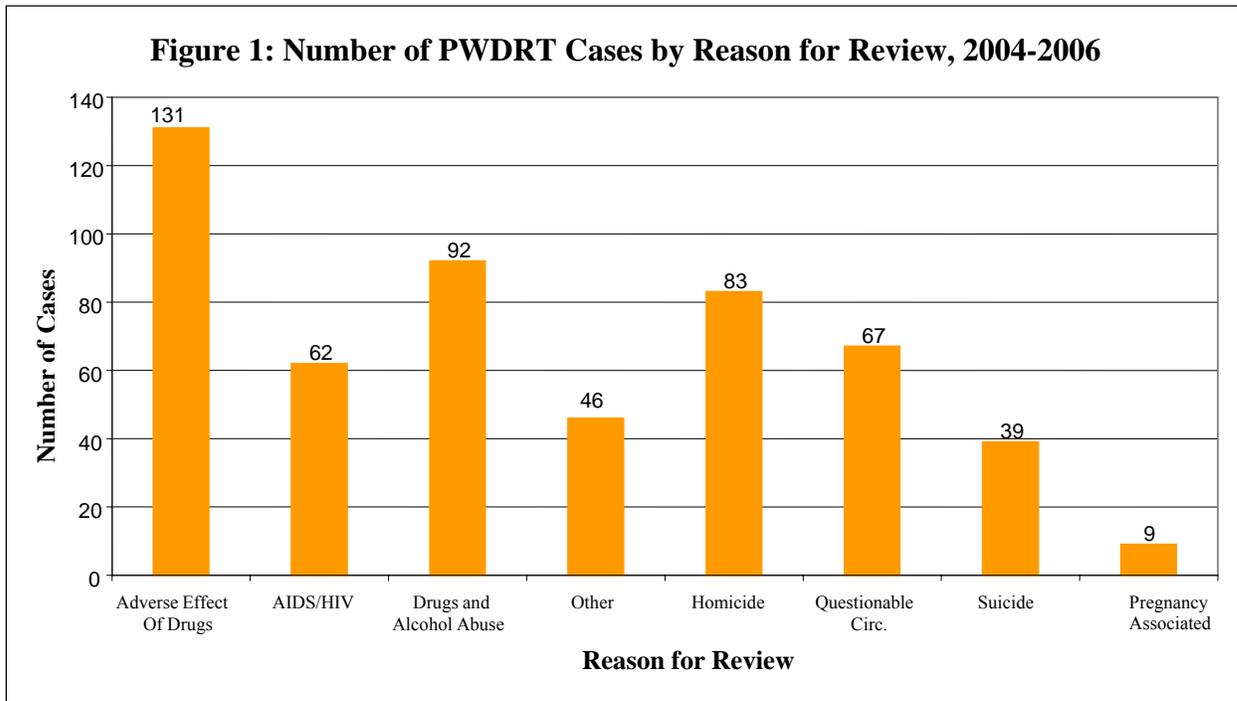
⁷ All but eight of the 1997 to 2006 deaths (n=3,159) selected for review were residents of Philadelphia County according to their death certificates or the City File. Eight women were selected for review because the Clinical Screening Committee and the Review Team determined that they were residents of Philadelphia, although this was not recorded on their death certificates.

Chapter 3. Domestic and Intimate Partner Violence

I. Violence-Related Deaths in Philadelphia

Violence-Related Deaths in Philadelphia, 2004-2006

PWDRT reviews those deaths of Philadelphia women in which the cause of death is known to be associated with violence, as well as all deaths that the Clinical Screening Committee has determined to have questionable circumstances. Figure 1 shows the breakdown of deaths reviewed by PWDRT by reason for review between 2004 and 2006.



Source: PWDRT data, n=529. Cases may be selected for review for multiple reasons and selection criteria varied each year due to fluctuating resources.

Between 2004 and 2006, 145 women of the 529 cases PWDRT, reviewed (27 percent) had a known history of DV.

Violence-Related Deaths in Philadelphia, 1997-2006

PWDRT reviewed twenty-two percent of all deaths to Philadelphia women ages 15-60 between 1997 and 2006⁸. Of the 3,159 women reviewed who died between 1997 and 2006, thirteen percent (n=410) were known to the review team as having a history of DV. Between 1997 and

⁸ The Philadelphia electronic City File calculates that 14,226 Philadelphia women between 15 and 60 have died between 1997 and 2006.

2006, 241 deaths reviewed by PWDRT were firearm (including 185 homicides, 49 suicides, five undetermined deaths and two accident deaths). Firearm deaths represent seven percent of violence-associated deaths reviewed by PWDRT since 1997.

Violence-Related Deaths in Philadelphia by Neighborhood, 2004-2006

Several Philadelphia neighborhoods (and zip codes) stand out as having the highest number of violence-related deaths to Philadelphia women between 2004 and 2006.

Neighborhoods (and zip codes) that experienced the highest (more than 23) number of violence-related deaths to women between 2004 and 2006 include (Appendix H, Map 1):

- Logan (19141)
- Nicetown (19140)
- Port Richmond (19134)
- Frankford (19124)

Neighborhoods (and zip codes) that experienced the highest (more than 4) homicide deaths to women between 2004 and 2006 include (Appendix H, Map 4):

- Logan (19141)
- Nicetown (19140)
- Point Breeze (19145)
- Frankford (19124)
- Port Richmond (19134)
- West Market (19139)

Neighborhoods (and zip codes) that experienced the highest (more than 3) number of firearm homicides deaths to women between 2004 and 2006 (Appendix H, Map 6):

- Logan (19141)
- Nicetown (19140)
- Point Breeze (19145)
- Port Richmond (19134)
- Fairmont (19121)

II. Domestic and Intimate Partner Violence

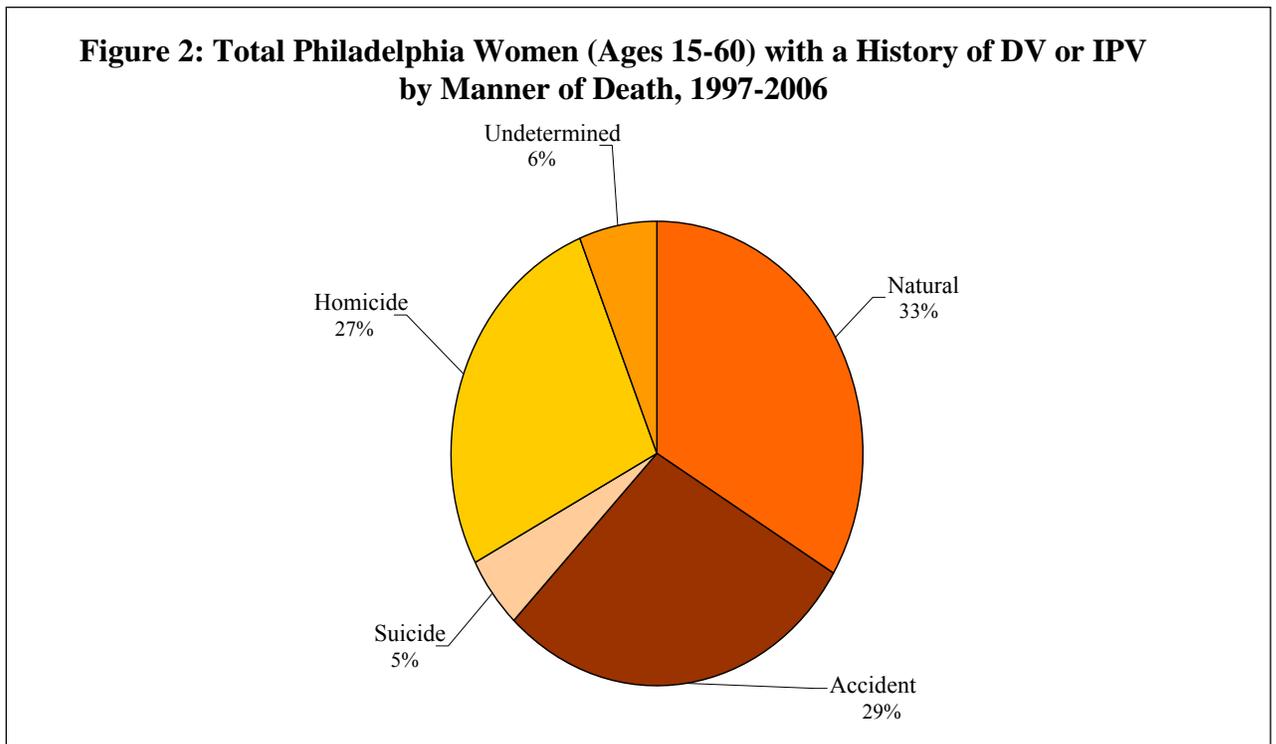
According to the Family Violence Prevention Fund, IPV Fact Sheet, women with a personal history of DV and/or IPV are more likely to display behaviors that can negatively affect their physical, mental, and social health (e.g., suicidal ideation and attempts, or abuse of drugs and/or alcohol). Untreated trauma can set the stage for many potentially lethal behaviors. Victims of DV or IPV can also be restricted by their abuser from accessing social and health services, which can result in negative health and/or employment (loss of productivity) consequences.

PWDRT began collecting DV and IPV information at the inception of the Team in 1997. Trend analysis of decedents with a history of domestic or intimate partner victimization shows that such violence was present in the lives of women across all manners of death (Table 3 and Figure 2), race (Figure 3), and ethnicity (Figure 4). Trend analysis of PWDRT data also indicates improved PWDRT collection of DV/IPV reporting beginning in 2001, whereby numbers of known DV and IPV victims are noticeably higher in 2001 than in any of the first four years of data collection.

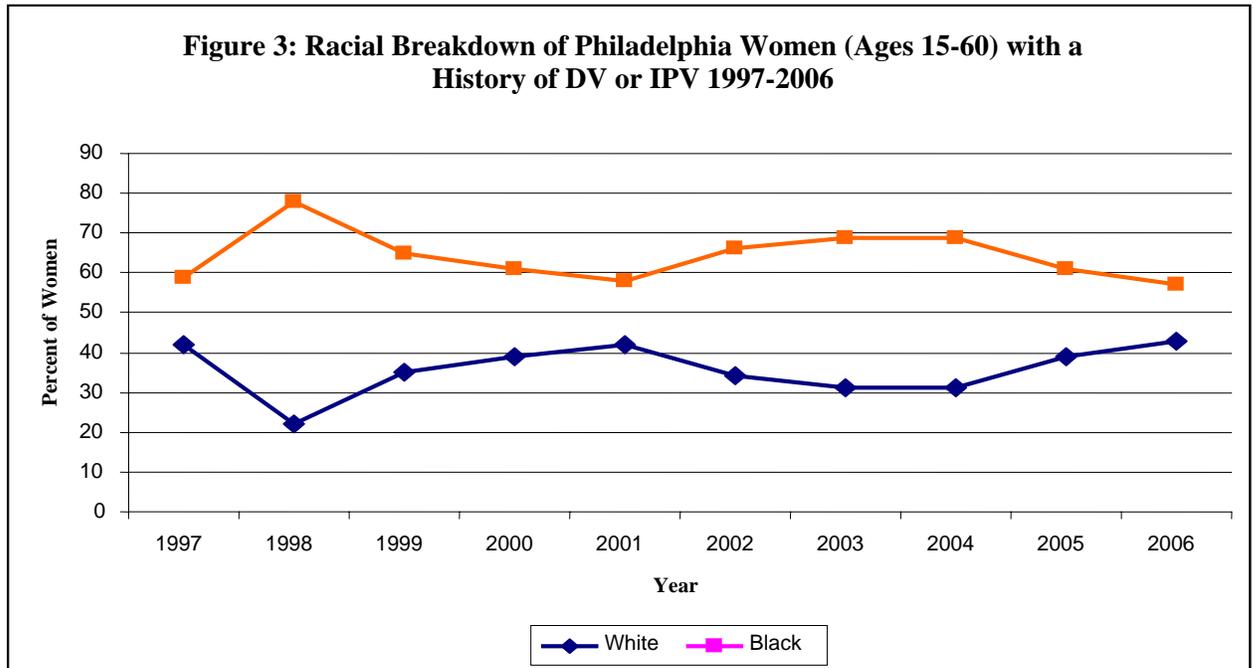
Table 3: Number and Percent of Philadelphia Women (Ages 15-60) with a History of DV or IPV, by Manner of Death, 1997-2006

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	TOTAL
	n (%)										
Natural	5 26%	2 16%	2 11%	5 17%	27 33%	26 42%	17 40%	1 6%	12 31%	40 44%	137 33%
Accident	1 5%	1 8%	2 11%	10 35%	31 38%	19 31%	11 26%	5 31%	15 38%	23 26%	118 29%
Suicide	1 5%	0 0%	0 0%	1 3%	6 7%	4 7%	1 2%	1 6%	2 5%	4 4%	20 5%
Homicide	10 53%	9 75%	15 79%	10 35%	14 17%	9 15%	11 26%	6 38%	5 13%	21 23%	110 27%
Undetermined	2 11%	0 0%	0 0%	3 10%	3 4%	4 6%	3 7%	3 19%	5 13%	2 3%	25 6%
TOTAL n	<i>19</i>	<i>12</i>	<i>19</i>	<i>29</i>	<i>81</i>	<i>62</i>	<i>43</i>	<i>16</i>	<i>39</i>	<i>89</i>	<i>410</i>

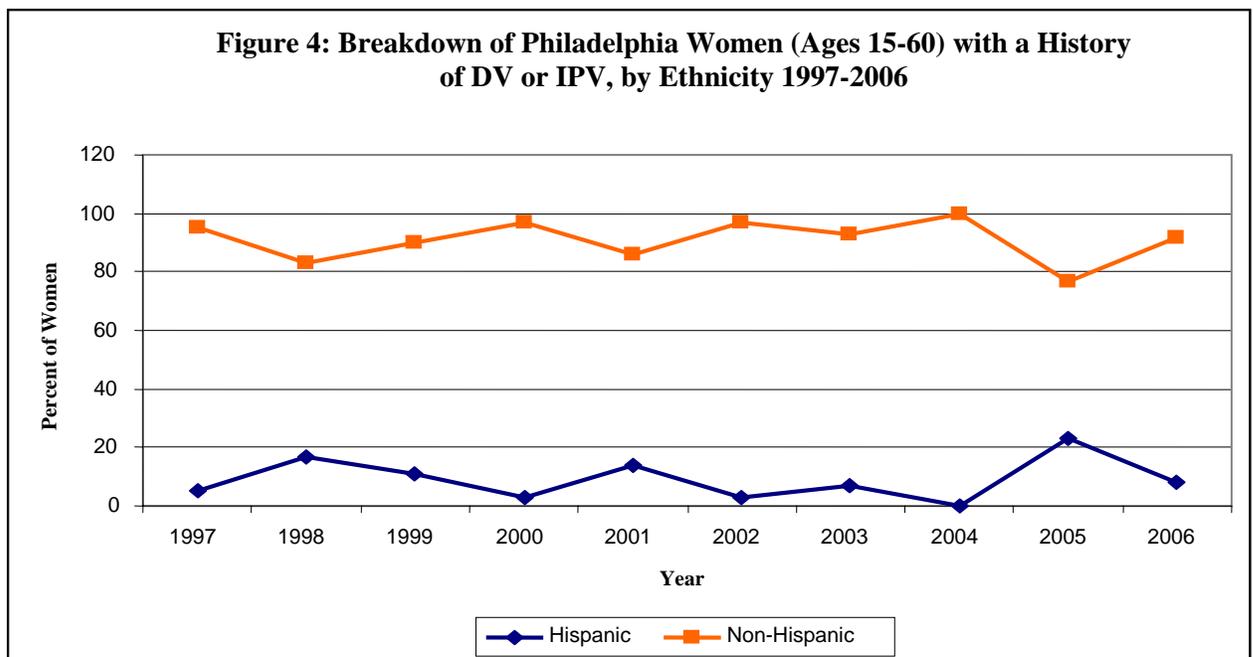
Source: PWDRT data, n=410 (27% overall)



Source: PWDRT data, n=410



Source: PWDRT data, n=410. Only women of Black or White Race are included in this analysis. Percents therefore are valid percents, totaling each year to 100 percent. Case selection criteria for PWDRT reviews changed from 2004 though 2006 as documented in the methodology section



Source: PWDRT data, n=410. Only women of Hispanic or Non-Hispanic reported ethnicities are included in this analysis. Percents therefore are valid percents, totaling each year to 100%. Case selection criteria for PWDRT reviews changed from 2004 though 2006 as documented in the methodology section.

Women with a History of Domestic or Intimate Partner Violence

Using indicators determined by a breadth of DV/IPV literature (CDC 2005); Crandall, Nathens, Kernic, Holt, & Rivara (2004); Brookoff, O'Brien, Cook, Thompson, & Williams (1997, for identifying women most at risk for victimization in domestic violence and/or intimate partner violence, the following data outlines the Team's findings about these known risk factors for violence.

Between 1997 and 2006, a total of 410 women reviewed by PWDRT were identified as having a known history as a victim of either DV or IPV. Below are some characteristics of these Philadelphia women:

Table 4: Women with a History of Domestic or Intimate Partner Violence

History of DV or IPV	1997 – 2006 (n = 410)
Age (mean average)	38
Black	58%, (n=239)
Non-Hispanic	90%, (n=369)
High School graduate	53%, (n=218)
Homeless or known to OESS	9%, (n=37)
Unemployed	75%, (n=306)
Personal and family histories included:	
Substance abuse	44%, (n=182)
Criminal history	35%, (n=143)
Diagnosis or mental health treatment	30%, (n=124)
History of sexual abuse as a child	7%, (n=29)
History of abuse or neglect as a child	10%, (n=39)
Perpetrator of child abuse or neglect	13%, (n=53)
Family history of child abuse or neglect, or child sexual abuse	6%, (n=26)
Family history of a perpetrator of child abuse or neglect	2%, (n=9)

Through future study of behavioral and social risk factors, we might be better equipped to identify women at greatest risk for abuse, as well as identify protective factors for women (CDC, 2005).

Information about perpetrators of DV or IPV is known to the Team only in cases of homicide. Please see the following section on Intimate Partner Homicide for further information on perpetrator characteristics.

III. Intimate Partner Homicides

The identification and review of intimate partner homicides provides PWDRT with a beginning point in documenting violence in the lives of Philadelphia women who die. PWDRT reviews all homicide deaths to Philadelphia women ages 15-60 for which a death certificate is available.

Research has shown that the rate of intimate partner violence (IPV) and the effects it has on a community's overall mortality and morbidity are staggering. A National Institute of Justice survey indicates that nearly 25 percent of women surveyed said that they had been raped and/or

physically assaulted by a current or former spouse, cohabiting partner or date at some point in their lifetime; 7.6 percent of men had been similarly victimized (Tjaden and Thoennes, 2000). Nationwide, IPV results in nearly two million injuries and 1,300 deaths every year (CDC, 2005).

While both men and women are victims of IPV, literature has shown that women tend to be more frequent victims of physical injury from IPV than men, and men tend to be more frequent perpetrators of IPV than women (Durose, Harlow, Langan, Motivans, Rantala, & Smith, 2005). DV homicides include homicides of women, men and children.

National data shows that between 1998 and 2002, of the approximately “3.5 million violent crimes committed against family members, 49 percent were crimes against spouses.” In addition, Durose, et al. (2005) wrote, “Females were 84 percent of spouse abuse victims and 86 percent of victims of abuse at the hands of a boyfriend or girlfriend.”

Because of the prevalence of IPV in society, PWDRT is particularly interested in the role IPV plays in the premature deaths of Philadelphia women. The Team aims to prevent IPV-related deaths by learning about the personal histories of the victim and the offender to better understand the relationship and events that lead up to the homicide.

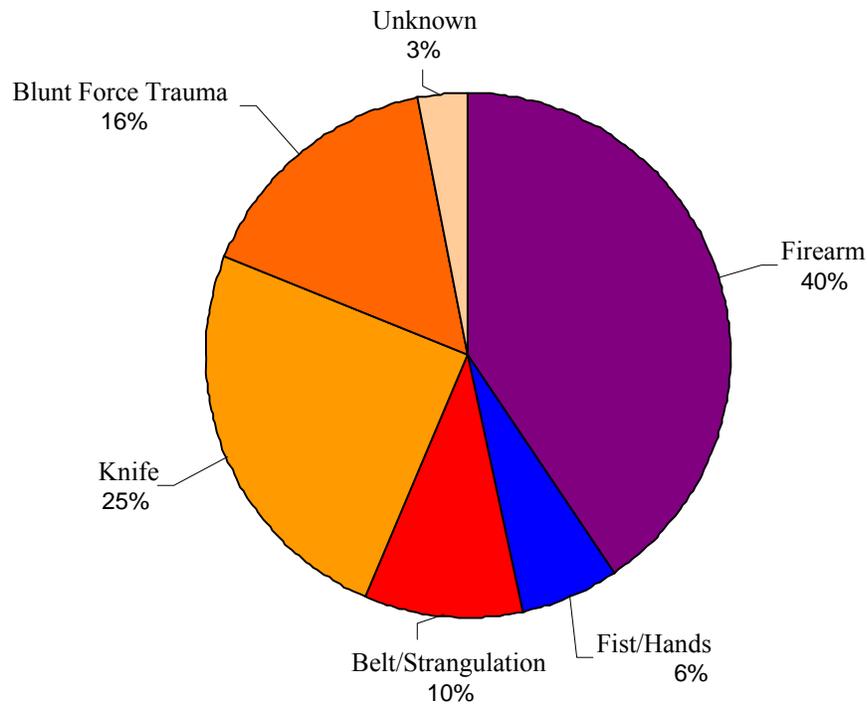
Intimate Partner Homicides, 2004-2006

PWDRT identified and reviewed 32 intimate partner homicides occurring between 2004 and 2006. These were cases in which the perpetrator was the decedent’s spouse/paramour, the decedent’s ex-spouse/ex-paramour, or was someone who had a history of intimacy with the decedent. In two out of five cases of intimate partner homicides (39 percent, n=12), the perpetrator was the decedent’s spouse/paramour and in five cases the perpetrators were the decedent’s ex-spouse/ex-paramour. There were also three homicides by acquaintance and three by strangers (rape). Two of the IPV homicides involved two perpetrators. The manner of the relationship with the decedents in the remaining nine IPV cases was unknown.

Women reviewed by PWDRT who were killed by an intimate partner ranged in age from 16 to 55, with a mean age of 30. The majority of these women were Black (81 percent, n=25).

One-half of intimate partner homicides took place in the decedent’s home (50 percent, n=16). Other places of events included another residence (n=9), vacant lots (n=3), hospital (n=1) or unknown locations (n=3). Forty percent (n=13) of intimate partner homicides cases were killed by firearm. Other weapons/methods included knives, strangulation, blunt force objects, fist and hands (Figure 5).

Figure 5: Weapons Use in IPV Homicides of Philadelphia Women (Ages 15-60), 2004-2006



Source: PWDRT data, n=32

Twenty-one of the 32 intimate partner homicide decedents were known to family court prior to their death. Two decedents sought final Protection From Abuse orders.

Of the 32 intimate partner homicide cases reviewed, 19 (60%) had contact with at least one of the service system agencies on the Team. Of these women, 13 had contact with two or more agencies, and several (four or more) women were “high-end users,” having contact with multiple agencies such as: City health centers, Women Against Abuse (24-hour hotline), Women in Transition, Women Organized Against Rape, Community Legal Services, the Office of Supportive Housing (OSH), and the Department of Behavioral Health.

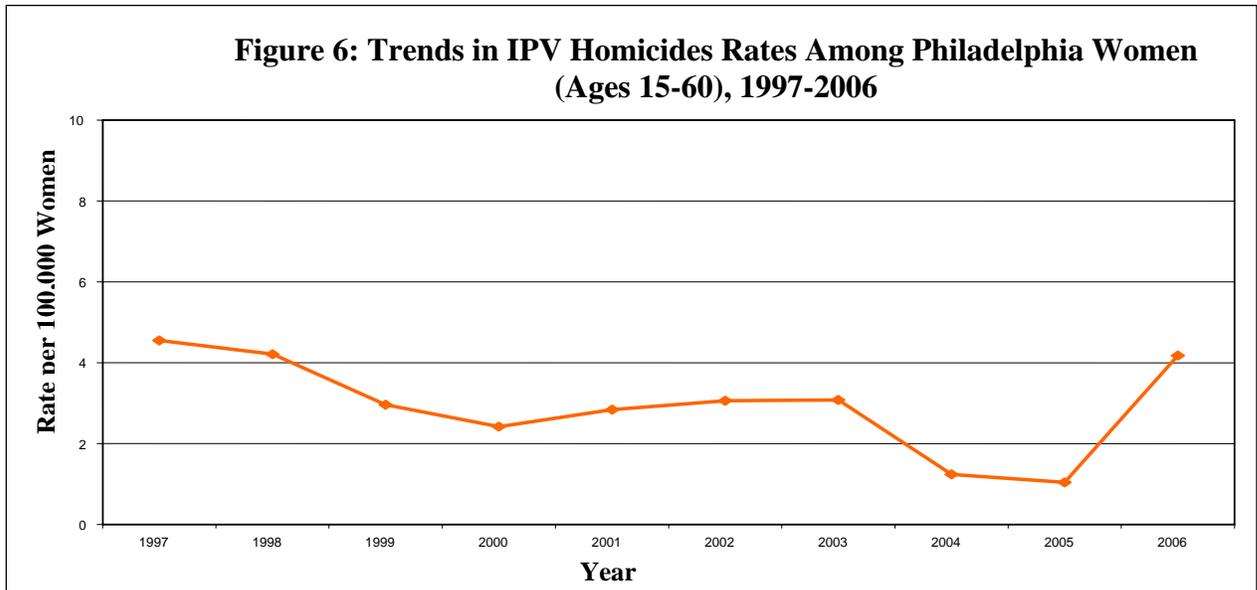
PWDRT found that seven (22 percent) of the decedents were known to have a history of mental health problems. One-quarter of the victims had a history of substance abuse (22 percent, n=7) of which 18 (56 percent) of the victims had positive toxicology (alcohol, drugs or both) at the time of death. In addition, seven (22 percent) of the victims were known by the criminal courts.

Perpetrator

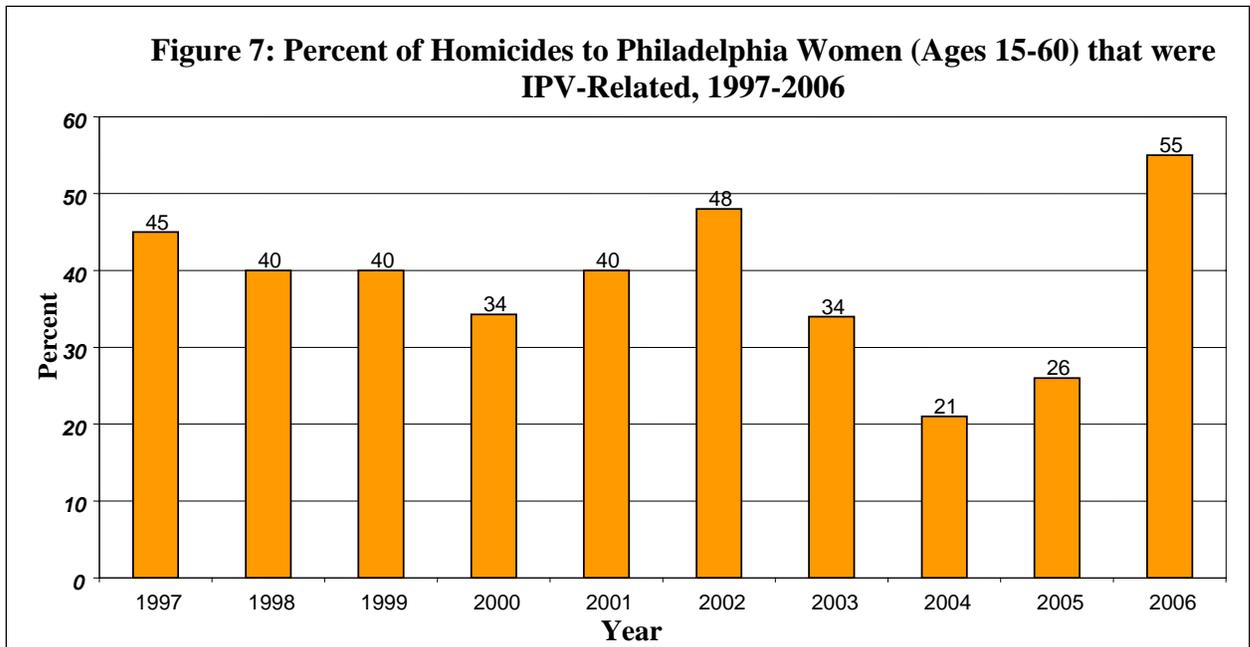
After committing a homicide, two perpetrators committed suicide, and four perpetrators attempted suicide. Of the 32 intimate partner homicide cases reviewed by PWDRT, five (16 percent, n= 5) women were known to have a made prior reports of DV to the police department.

Intimate Partner Homicides, 1997-2006

Intimate partner homicides accounted for 40 percent of all homicides between 1997 through 2006. Averages of 14 women per year were killed between 1997 through 2006 due to IPV. The number and rates of intimate partner homicides of women in Philadelphia have declined between 1997 and 2005 until a slight increase in 2006 (Figures 6 and 7). This reduction in homicide deaths is particularly evident between 2003 and 2005. Overall, as homicide rates increased, rates of IPV homicides increased as well (Figure 6 and 7). Locations of IPV homicides, 2004-2006, are mapped in Appendix H, Map 5.

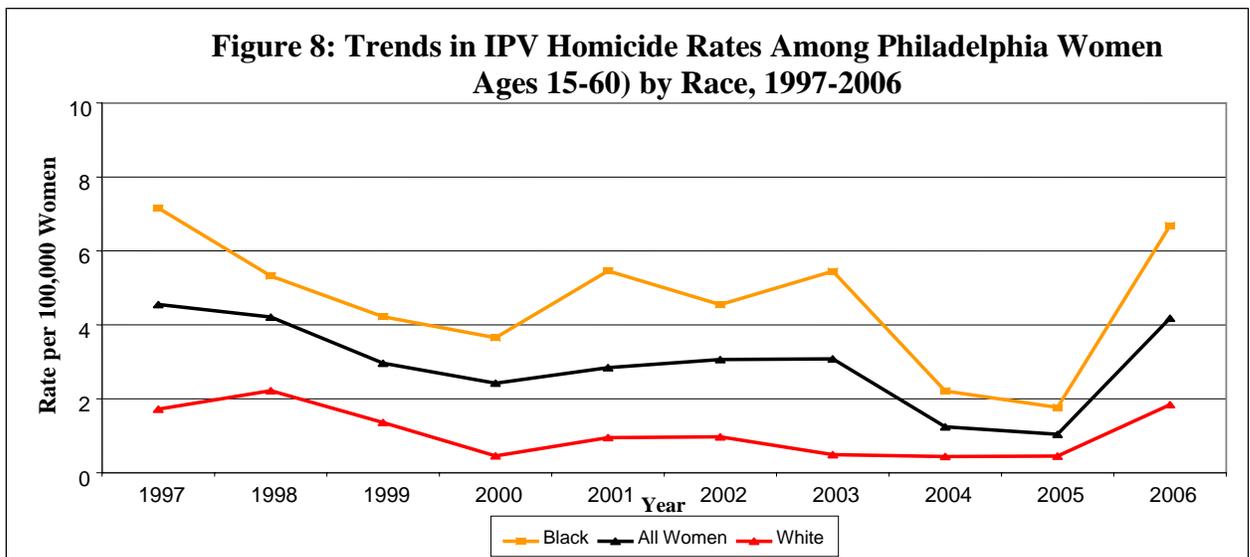


Source: PWDRT data, n=142



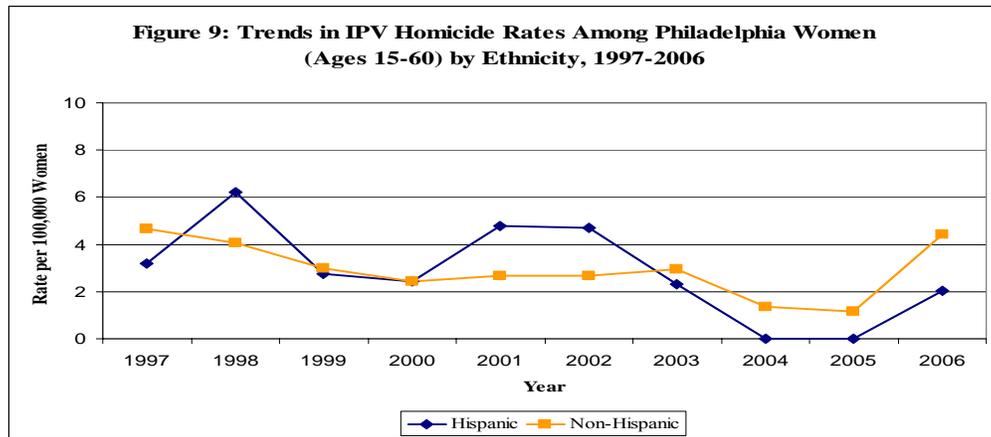
Source: PWDRT data, n=142

In comparison to figures 6 and 7, there was a reduction of homicide deaths during 2003-2005. In 2006, as homicide rates increased, rates of IPV homicides increased as well. Figures 8 and 9 shows the trends in the rates of IPV homicide among Black and White women, as well as Hispanic and Non-Hispanic between 1997 through 2006.



Source: PWDRT data, n=142

The overall decrease in the number and rate of IPV homicides over the last seven years in Philadelphia is differentially reflected across racial and ethnic groups until 2006 where there is a slight increase. Despite similar trends, the IPV homicide rate among Black women in Philadelphia since 1997 has been higher than that of White women. (Figure 8)



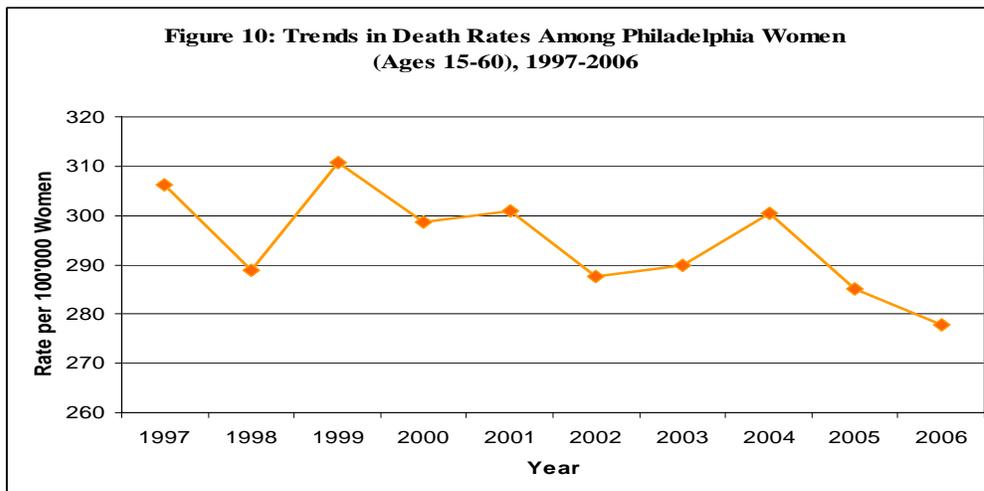
Source: PWDRT data, n=142

Hispanic women have died at a rate lower than Non-Hispanic women have in three out of the ten years in Philadelphia.

Chapter 4. Data Findings and Trends by Manner of Death

I. Overall Death Rates Among Philadelphia Women, 1997-2006

During 1997 and 2006, 14,223 Philadelphia women age 15-60 died. Figure 10 shows the variation in the death rate since the inception of PWDRT.



Source:

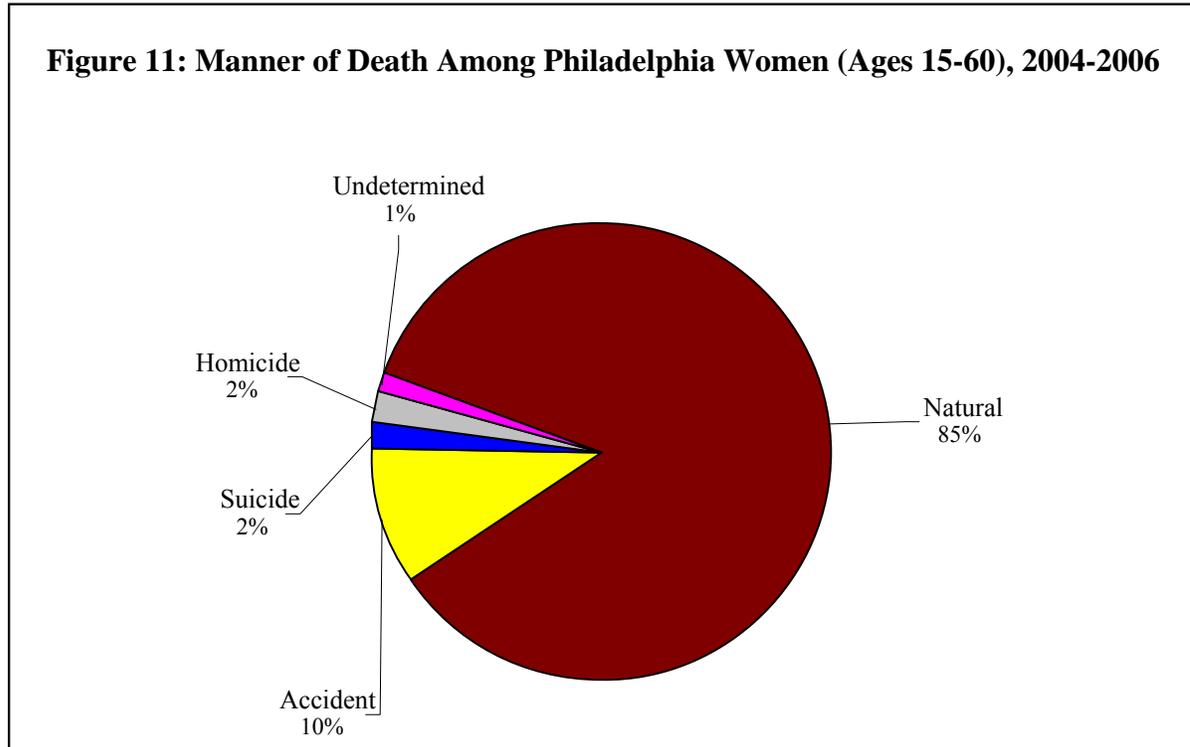
*Philadelphia Vital Statistics 1997-2006, Philadelphia Department of Public Health, n=14,223
(At the time of this report all reference to 2006 Philadelphia Vital Statistics Report numbers are preliminary data)*

II. Deaths Among All Philadelphia Women, 2004-2006

Between 2004 through 2006, 4,137 Philadelphia women ages 15 to 60 died (1,449 in 2004, 1,361 in 2005 and 1,327 in 2006). The death rate for this age group is decreasing at 300.4 per 100,000 women in 2004; 285.1 per 100,000 women in 2005, and 277.9 per 100,000 women in 2006.

Manner of Death, 2004-2006

Of these 4,137⁹ deaths, natural causes accounted for 83 percent (n=3,438), accident deaths accounted for 10 percent (n=400), with homicide and suicide accounting for two percent respectively (n=86) and (n=68) each, and one percent (n=58) of deaths classified as undetermined (Figure 11).



Source: Philadelphia Electronic City File 2004 -2006 Philadelphia Department of Public Health, n=4,050

*Manner of Death was unavailable at the time the Vital Statistics Files were released for 2004- 2006 deaths in 87 cases.

Race and Ethnicity

In reporting information about race and ethnicity, PWDRT uses race and ethnicity categories provided on the death certificates: race defined as Black, White, American Indian, and other; ethnicity categorized as either Hispanic or non-Hispanic.

There is a noticeable disparity in the death rate among Black women, who constitute 60 percent of all deaths, yet made up only 37 percent (n=2,470) of the population between 2004 and 2006. Asian women also have a disproportionately high number of deaths; Asian women account for nearly six percent of all deaths to women 15-60 years in Philadelphia, though they constitute just one percent (n=74) of the population in 2004, 2005 and 2006.

⁹ Manner of death was unknown or pending at the time the Electronic City Files of 2004 – 2006 deaths were released in 87 cases; percentages are therefore calculated based on the 4,137 cases for which manner of death was known. Percentages may not add to 100% due to rounding of decimals places.

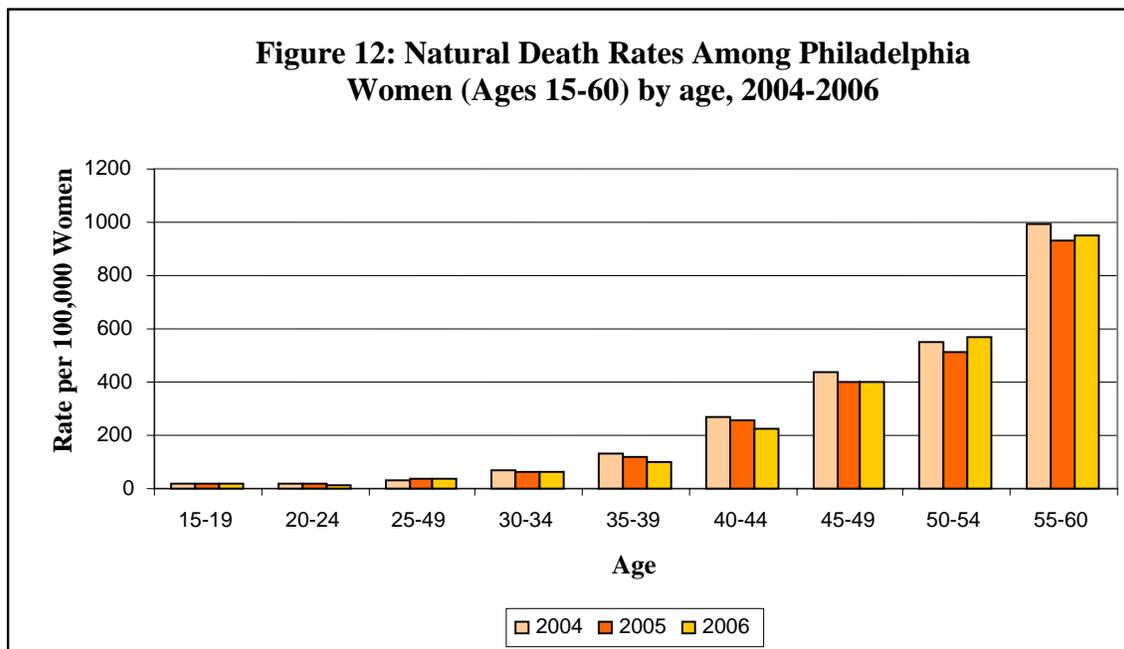
III. Natural Deaths

Natural Deaths, 2004 - 2006

A third of Philadelphia women reviewed by PWDRT between 2004 and 2006 were natural deaths (37 percent, n=194). During this time, natural deaths accounted for more than 80 percent of deaths to Philadelphia women in this age group. PWDRT found that between 2004 and 2006, 53 women (27 percent) who died by natural means also had a history of DV

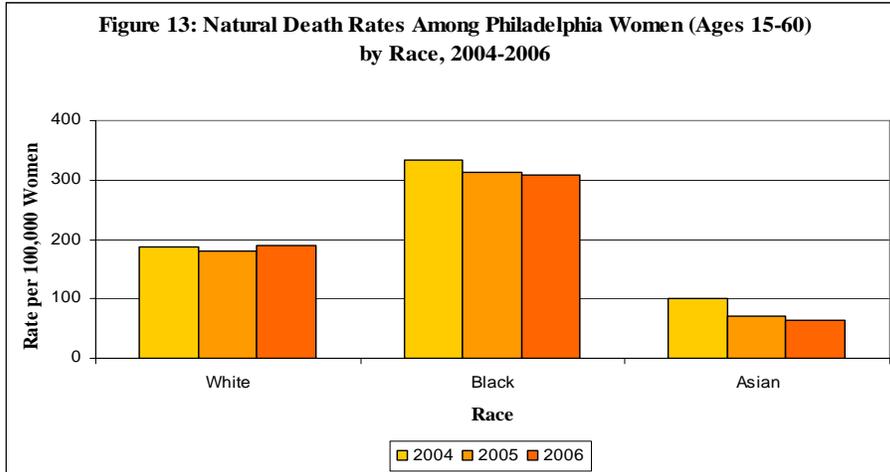
The natural death rate for Philadelphia women ages 15-60 is decreasing; 249.3 per 100,000 in 2004, 233.6 per 100,000 in 2005 and 235 per 100,000 in 2006. This rate varies among Philadelphia women by age, race and ethnicity.

The death rate due to natural causes increases with age, reflecting deaths due to disease and chronic conditions (Figure 12).



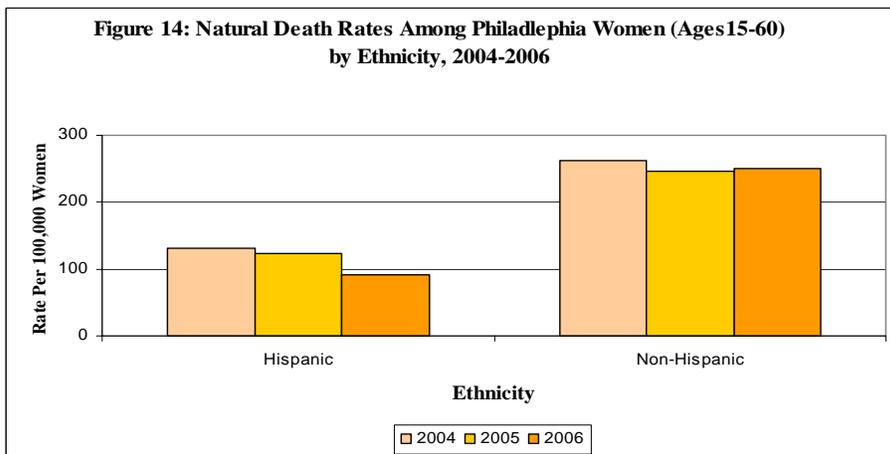
Source: Philadelphia Vital Statistics 2004 - 2006, Philadelphia Department of Public Health, n=3,438

Between 2004 and 2006, natural death rates were highest among Black women, (333.34 per 100,000 in 2004, 312.30 per 100,000 in 2005, and 309.15 per 100,000 in 2006). Asian women had the lowest rates of natural death (100.19 per 100,000 in 2004, 69.83 per 100,000 in 2005, and 64.19 per 100,000 in 2006). (Figure 13).



Source: Philadelphia Vital Statistics 2004 - 2006 Philadelphia Department of Public Health, n=3,438

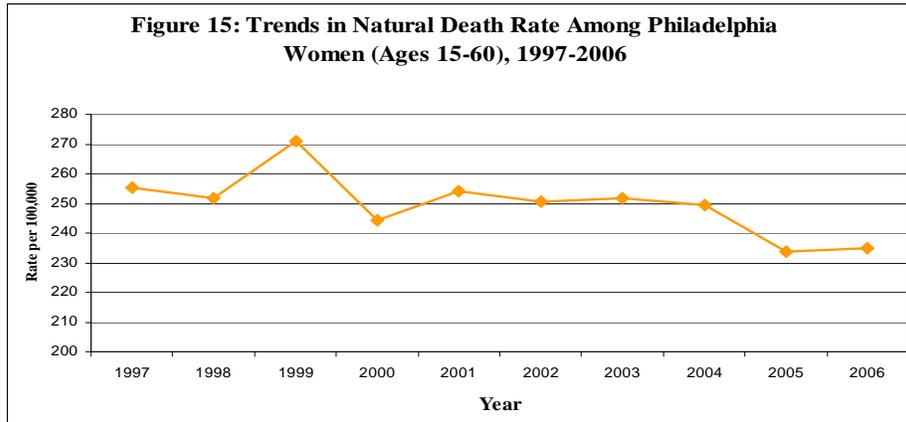
Non-Hispanic women have higher natural death rates (261.42 per 100,000 women in 2004, 246.56 per 100,000 women in 2005 and 250.32 per 100,000 women in 2006) than Hispanic women (Figure 14).



Source: Philadelphia Vital Statistics 2004- 2006, Philadelphia Department of Public Health, n=3,438

Natural Deaths, 1997-2006

Between 1997 and 2006, there were 11,914 natural deaths among women ages 15-60 in Philadelphia. PWDRT reviewed 1,537 of these natural deaths. Of the natural deaths reviewed, 137 (9 percent) had a known history of DV. The natural death rate among Philadelphia women ages 15-60 varied by year, with the highest natural death rate in 1999 (271.17 per 100,000 women) (Figure 15).



Source: Philadelphia Vital Statistics 1997-2006, Philadelphia Department of Public Health, n=11,914

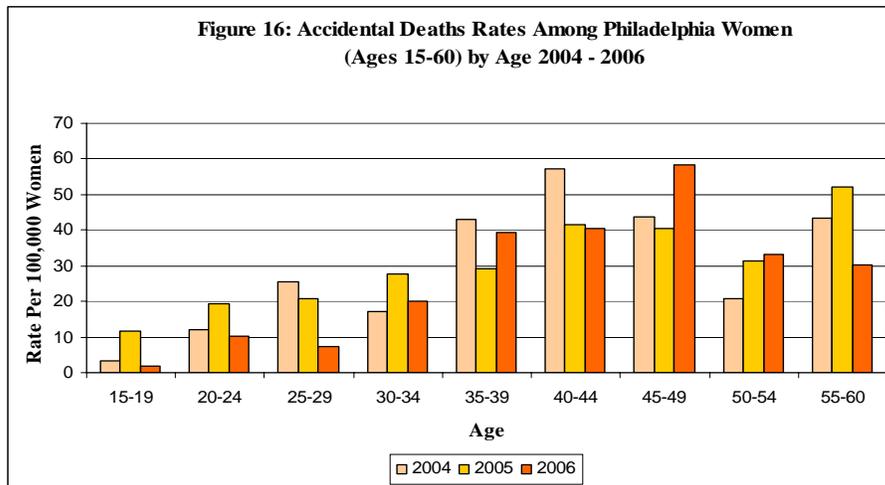
Natural deaths are the most common manner of death among Philadelphia women (Ages 15-60). Philadelphia's zip codes 19140, 19141, and 19134 have the highest rates of deaths due to natural causes among this population. A summary of natural death rates (2004-2006) by zip code is available in Appendix H, Map 2.

IV. Accident Deaths

Accident Deaths, 2004 - 2006

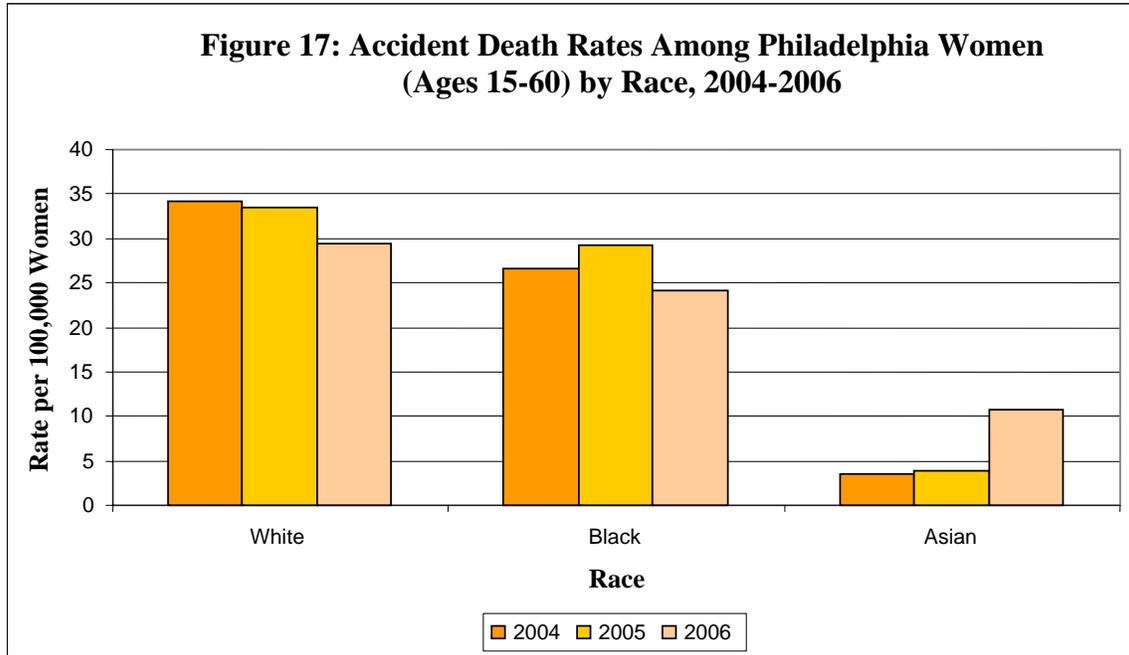
One out of four women PWDRT reviewed who died between 2004 and 2006 died as a result of accident death (n=165). Accident deaths include deaths such as motor vehicle crash, fall, drowning, and poisoning, as well as drug overdose. PWDRT found that between 2004 and 2006 43 women (26 percent) who died by accident also had a history of DV.

Philadelphia County accident death rates for women, ages 15-60, in 2004 - 2006 were 28.7, 29.3 and 32.2 per 100,000 women, respectively. There are higher rates of accident deaths in the middle age groups. Women ages 40 to 44 had the highest accident death rate at 57.4 and 41.7 deaths per 100,000 women in 2004 and 2005 respectively, while women ages 45 to 49 had the highest accident death rate at 58.2 deaths per 100,000 women in 2006 (Figure 16).



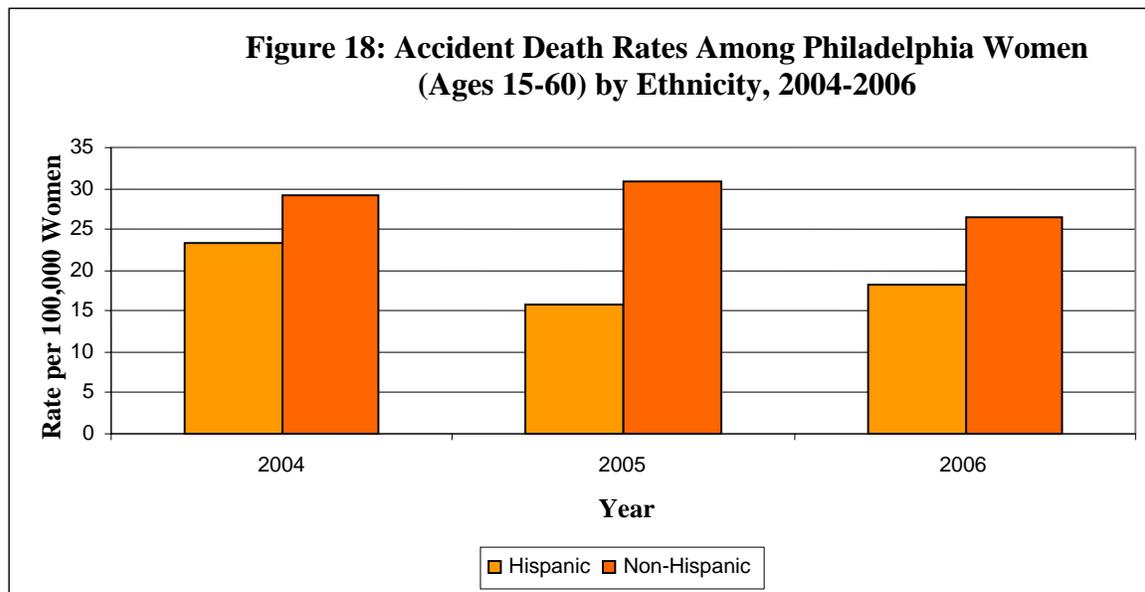
Source: Philadelphia Vital Statistics 2004 - 2006, For the purpose of this report age groups 55-59 and 60 were grouped together so rates appear higher. Vital statistics age categories vary from PWDRT. In addition, while the Philadelphia Department of Public Health, reported n=400. PWDRT reviewed all accident deaths (n=165) during this time period.

Figure 17 shows the disparity in accident death rates by race. The rate for accident death among White women ages 15-60, in 2004 – 2006 (34.1, 33.5 and 29.5 per 100,000 women, respectively) are more than the rate for Black women in the same years 2004 – 2006 (26.6, 29.3 and 24.1 per 100,000 women, respectively). Accident deaths among Asian women was relatively low compared to other races, but was highest in 2006 at 10.7 per 100,000 women in comparison to 2004 and 2005 at 3.5 and 3.9 deaths per 100,000 respectively. (Figure 17)



Source: Philadelphia Vital Statistics 2004-2006, Philadelphia Department of Public Health, n=400. PWDRT did not review all accident deaths during this time period (n=165).

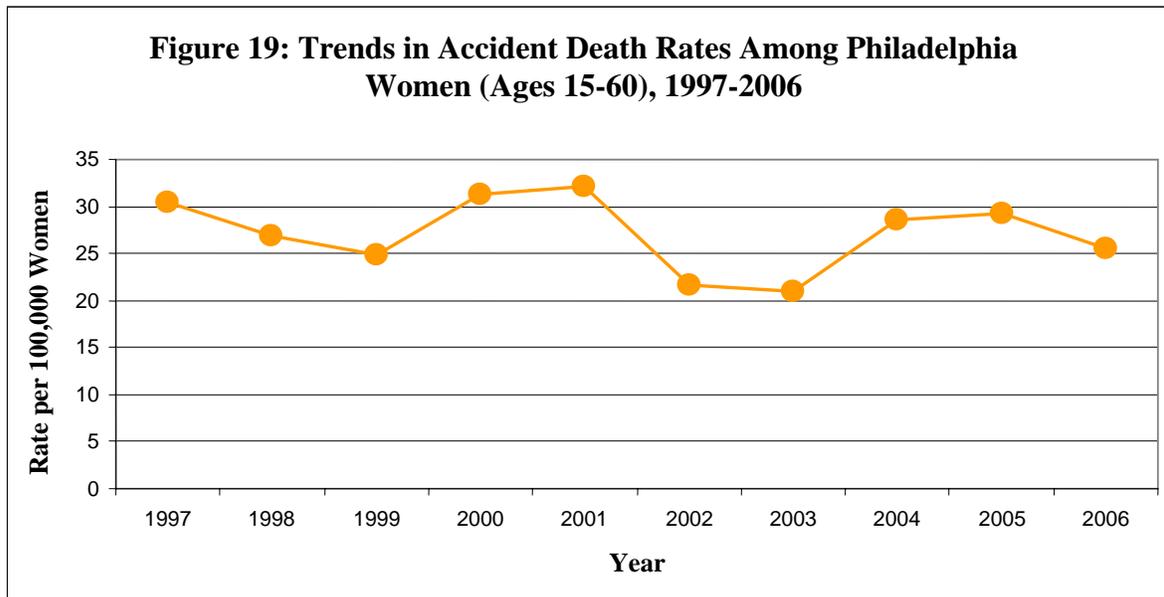
Figure 18 shows accident death rates for Philadelphia women by Hispanic origin. In 2004, the rate for Non-Hispanic women is more than that of Hispanic women (29.1 per 100,000 and 23.3 per 100,000, respectively), In 2005, the rate for Non-Hispanic women is more than that of Hispanic women (30.9 per 100,000 and 15.90 per 100,000, respectively) as well as in 2006 the rate for Non-Hispanic women is still greater than Hispanic women (26.39 per 100,000 vs. 18.2 per 100,000, respectively).



Source: Philadelphia Vital Statistics 2004 - 2006, Philadelphia Department of Public Health, n=4001. PWDRT did not review all unintentional injury deaths during this time period (n=165).

Accident Deaths, 1997-2006

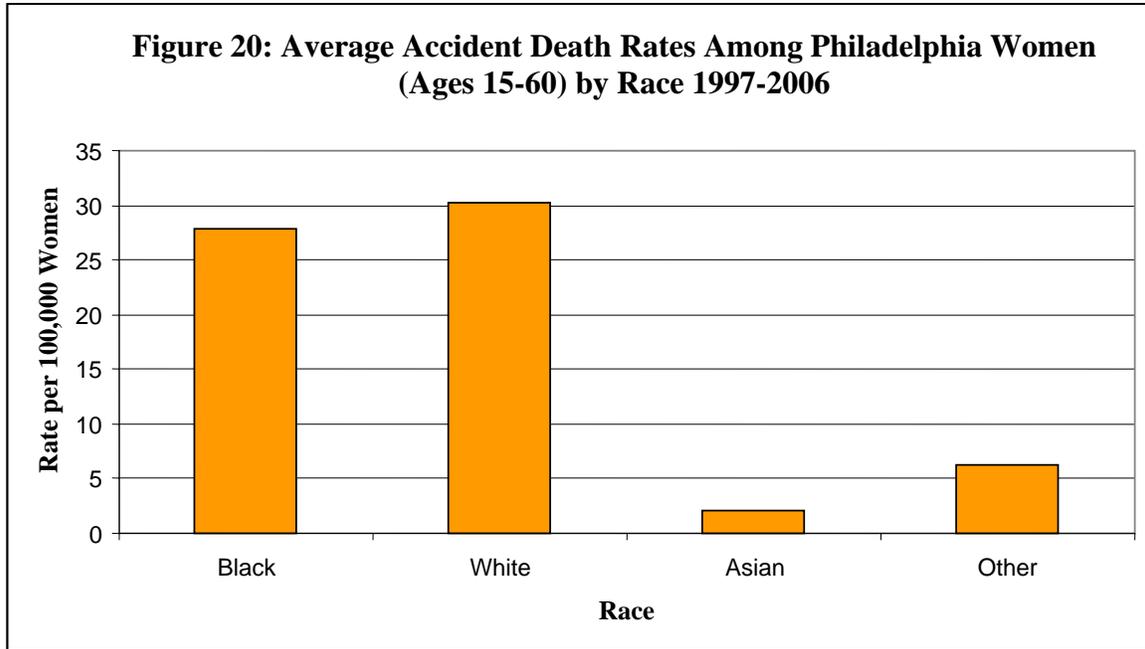
PWDRT has reviewed the deaths of 869 Philadelphia women who died as a result of an accident between 1997 and 2006. The rates of accident deaths have varied moderately during this time period, with a peak in 2001 of 32.1 deaths per 100,000 women, and a low in 2003 of 21.0 deaths per 100,000 women (Figure 19). Between 2004 and 2006, three east-central Philadelphia zip codes experienced high accident death rates at more than 23 deaths per 100,000 women. Southern Philadelphia also experienced elevated accident death rates. For rates by zip code, see Appendix H, Map 3.



Source: 2001 PWDRT Report (1997-2003) and Philadelphia Vital Statistics 2004 -2006, Philadelphia Department of Public Health) (n=1,321).¹⁰ A total of 869 accident deaths were reviewed.

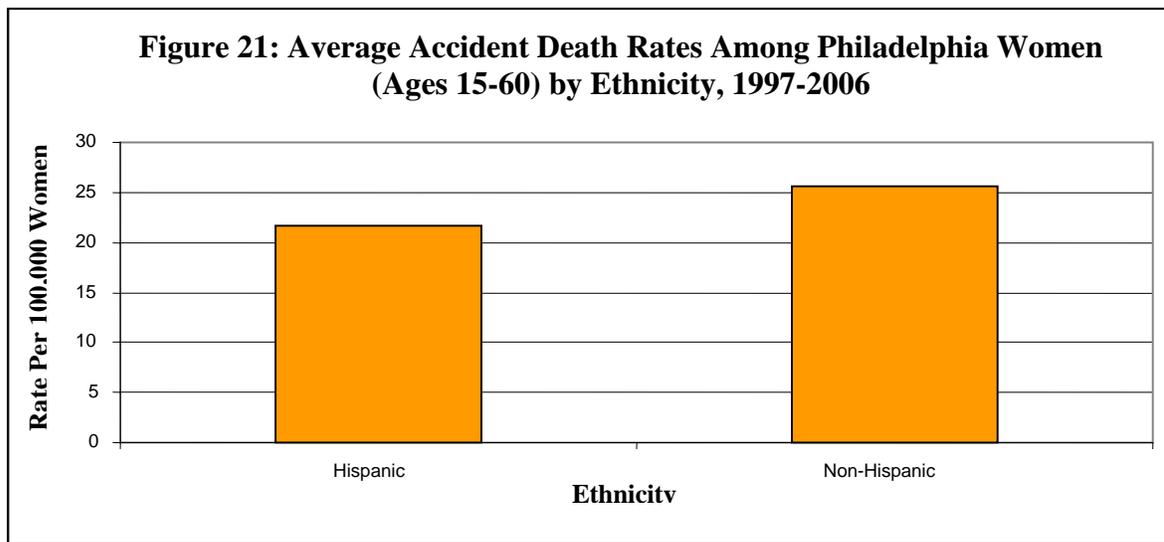
The ten-year average (1997-2006) rates of accident deaths by race are shown in Figure 20. White women had a slightly higher average rate of accident deaths (30.2 deaths per 100,000 White women, compared to 27.8 in Black women). The rates for women of Asian and “other” races were relatively low (2.1 deaths per 100,000 Asian women and 6.3 deaths per 100,000 women of an “other” race).

¹⁰ PWDRT was unable to use Vital Statistics data for the entire seven-year period of 1997-2003 for this analysis due to an incomplete list of E Codes, or injury codes, and thus calculated rates based on previous PWDRT reporting and available 2002 and 2003 vital statistics data.



Source: PWDRT Report (1997-2006) and Philadelphia Vital Statistics 2004-2006, Philadelphia Department of Public Health (n=1321). A total of 869 accident deaths were reviewed.

Figure 21 shows the ten-year average (1997-2006) of accident death rates for Philadelphia women by Hispanic origin. The rate for Non-Hispanic women is more than that of Hispanic women (25.6 per 100,000 and 21.7 per 100,000, respectively).



Source: PWDRT Report (1997-2003) and Philadelphia Vital Statistics 2004-2006, Philadelphia Department of Public Health. A total of 869 accident deaths were reviewed.

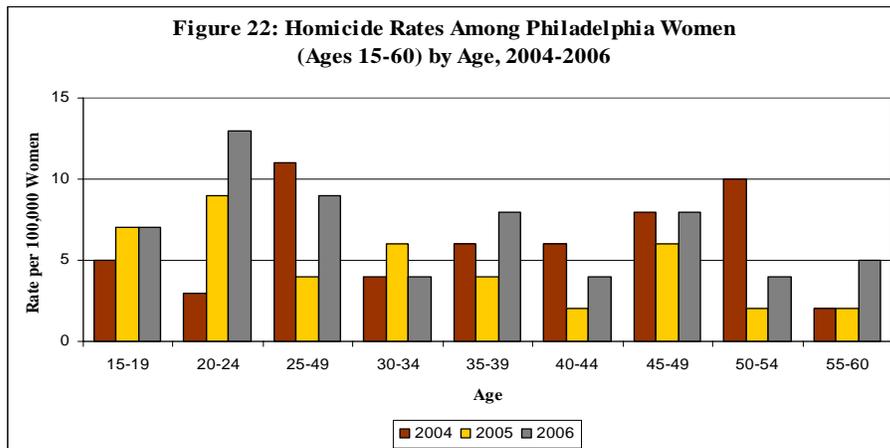
PWDRT found that between 1997 and 2006 160 women (18 percent) who died by accident also had a history of DV. DV is the leading cause of injury among all women (American Institute on Domestic Violence, 2001). While injuries from domestic and intimate partner violence are not always fatal, it is not uncommon for women to have serious injuries prior to a fatal injury. “One

study found that 44 percent of women murdered by their intimate partner had visited an emergency department within two years of the (ir) homicide” (CDC, 2005).

V. Homicides

Homicides, 2004 - 2006

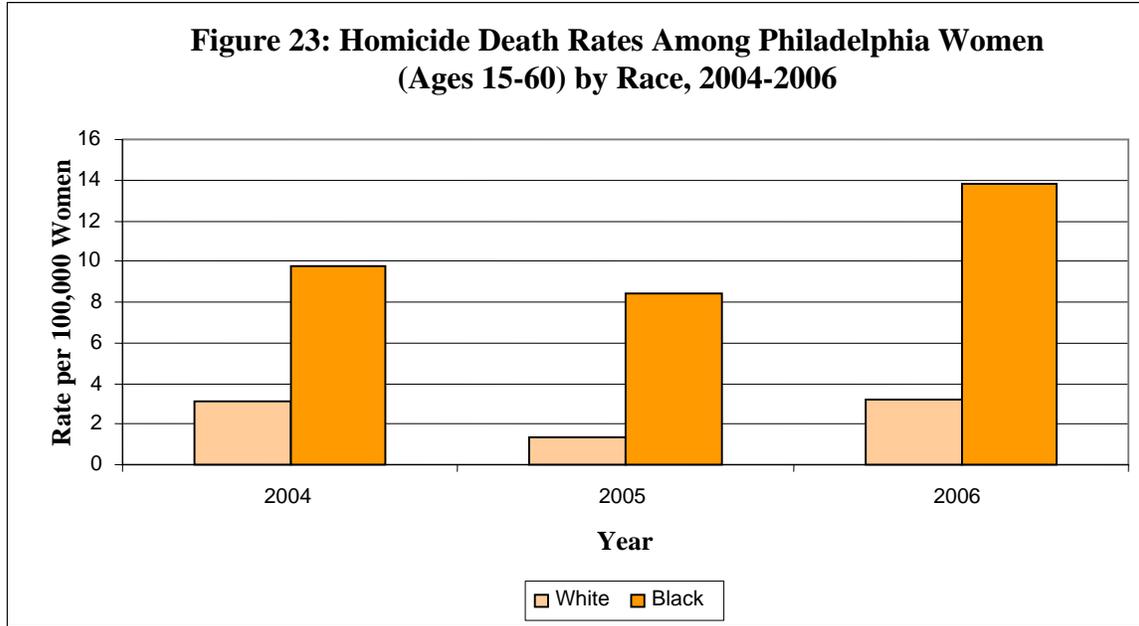
PWDRT reviewed all homicides identified by Philadelphia County Vital Statistics during each review year for which a death certificate was available. PWDRT identified and reviewed 83 homicide cases among Philadelphia women (ages 15-60) that occurred during 2004 and 2006¹¹. These deaths accounted for eleven percent of all deaths to Philadelphia women reviewed in those years. According to Philadelphia County Vital Statistics, the age-specific homicide rates for women between the ages of 15 and 60 show much variability. Because of the relatively small number of these deaths, the rates will be unstable over time. Figure 22 shows rates for several specific age groups.



Source: Philadelphia Vital Statistics 2004 - 2006, Philadelphia Department of Public Health, n=83.

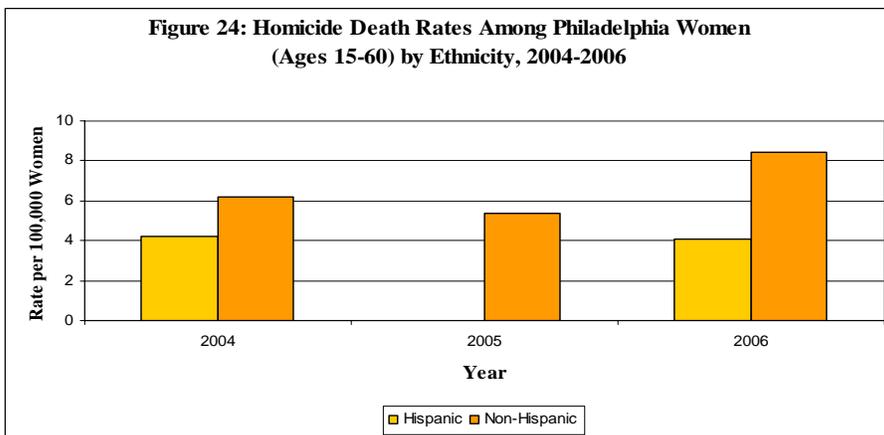
Figure 23 shows the disparity in homicide rates by race. The rate for homicides among Black women ages 15-60 in 2004 – 2006 (9.8, 8.4 and 13.8 per 100,000 women, respectively) are more than the rate for White women in the same years 2004 – 2006 (3.1, 1.4 and 3.2 per 100,000 women, respectively).

¹¹ PWDRT reviewed three fewer homicides cases than vital stats between 2004- 2006. This is due to the death certificates being unavailable or cases pending at the time of review.



Source: Philadelphia Vital Statistics 2004 - 2006, Philadelphia Department of Public Health, n=89. PWDRT reviewed three fewer homicide cases during this time period.

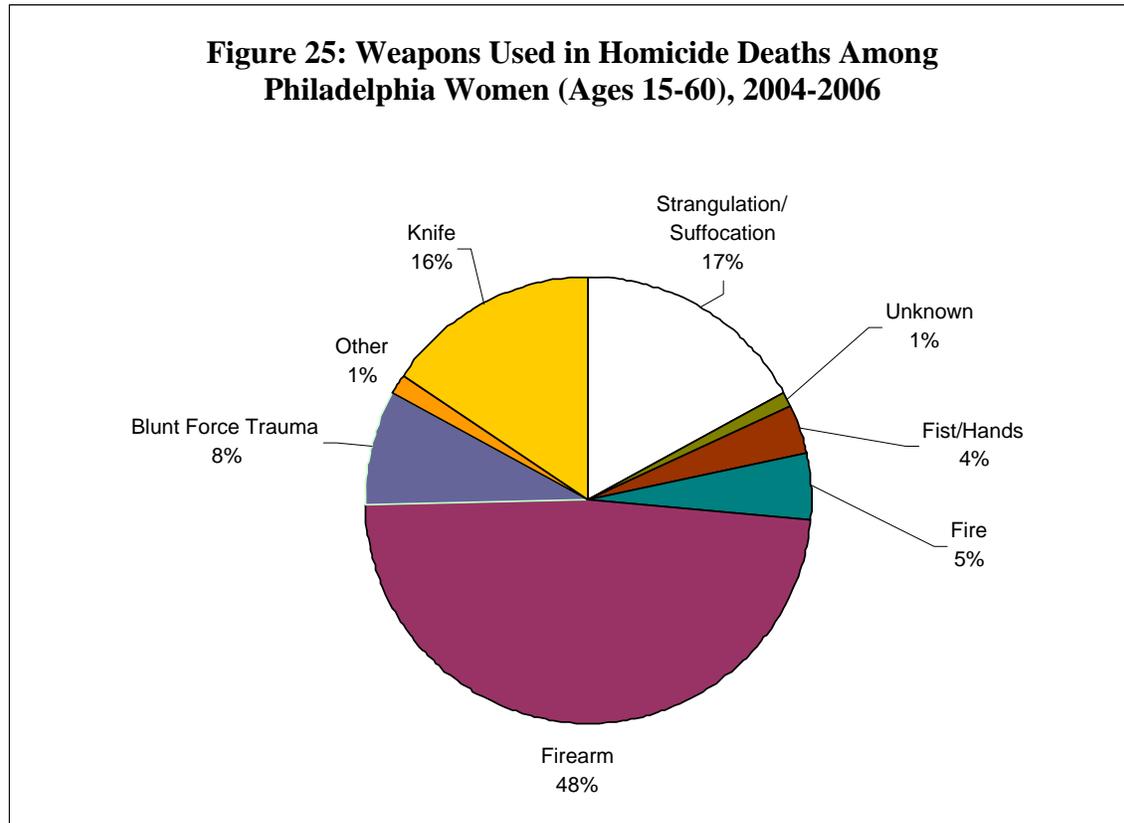
Figure 24 shows the homicide death rates for Philadelphia women of Hispanic origin. Between 2004 and 2006, Hispanic women had lower homicide death rates compared to non-Hispanic women. According to vital stats, there were no homicides to women of Hispanic origin in 2005, compared to women of non-Hispanic decent (5.4 homicides per 100,000 Non-Hispanic in 2005). In 2004, there were 4.2 homicides to Hispanic women compared to 6.2 non-Hispanic women per 100,000 and 4.1 homicides to Hispanic women compared to 8.4 non-Hispanic women per 100,000 in 2006.



Source: Philadelphia Vital Statistics 2004- 2006, Philadelphia Department of Public Health, n=68. PWDRT identified and reviewed an additional seven homicides during this time period.

PWDRT found that firearms were the predominant weapons used in homicides of women between 2004 and 2006, accounting for 48 percent (n=40) of the cases (Figure 25). Out of the 40 firearm cases, 29 involved a handgun, eight involved an unknown firearm type, and three

involved shotguns. Strangulation/suffocation was the second leading cause of death (17 percent, n=14).



Source: PWDRT data, n=83

Of the 83 women homicide victims between 2004 and 2006, 29 percent (n=24) had a known criminal history with the justice system. Seven percent (n=6) of the victims were actively involved with the criminal justice system at the time of their deaths (one bench warrant and five open cases). Ten percent (n=9) of decedents in the homicide cases, had prior history with prostitution.

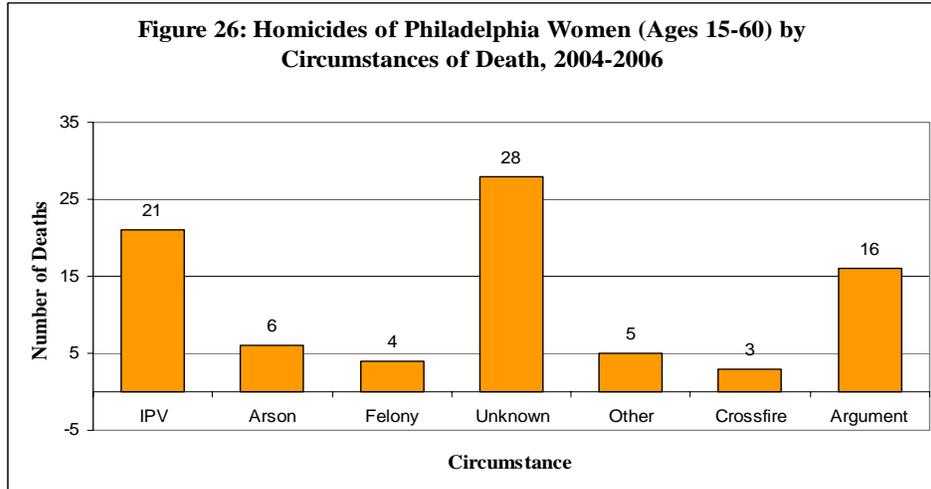
With respect to location, 49 percent of the homicide events (n=41) occurred in the decedent's own residence. Approximately 16 percent (n=13) occurred at other residence, and another 11 percent (n=9) occurred in a street setting. Five homicides occurred in vacant lots, two homicides took place at recreation centers, one in a vehicle, and one in a hospital. The actual location or occurrences of the homicides were unknown or missing in nine cases (11 percent).

The lives of the victims were further examined to identify women who had a known history of substance abuse. It was found that in 28 percent of the homicides (n=23), the victim had a known history of substance abuse. Toxicology reports were run on all 83 decedents. According to the toxicology exams, 47 percent (n=39) of the women tested positive for drugs, alcohol, or multiple substances at the time of their deaths: five for alcohol, 22 for drugs, and 12 for both alcohol and drugs.

PWDRT was also able to determine that five of the homicide victims were pregnant at the time of the death, and two were determined to have been pregnant in the year before their homicide and within 42 days of pregnancy. However, this does not represent the true number of pregnancy-

associated deaths, because the Team is not always aware of how many women were pregnant within 365 days of her death.

With regard to circumstances/motives surrounding the 83 homicide deaths (Figure 26), PWDRT found that intimate partner violence (IPV) was the most frequent known circumstance of all homicide cases at 25 percent (n=21). Thirty-two (39 percent) of the homicide victims had a known history of DV.



Source: PWDRT data, n=83

Perpetrators

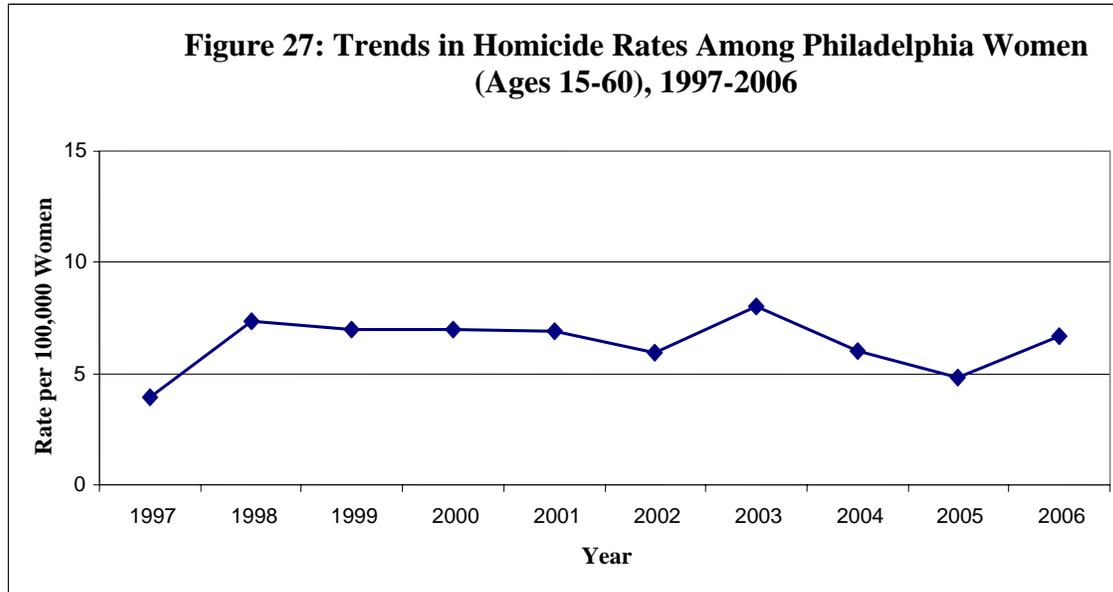
To better understand the conditions involved in the homicides, PWDRT looked at selected characteristics of perpetrators who were identified by the police. A total of 51 perpetrators were identified. In 51 percent (n=42) of the 2004-2006 homicide (n=83) cases, the police had identified the perpetrator(s) at the time of the PWDRT review meetings. Two of the identified perpetrators (4 percent) committed suicide after the event.

Nineteen perpetrator(s) had previously been arrested in 51 percent (n=42) of the homicide cases where a perpetrator was identified. At the time of the homicide, nine perpetrators were on probation or parole, two had an open case and eight were known to have completed any prior sentencing by the time of the homicide. Twenty-three (54 percent) were not known to have any prior contact with the criminal system.

In the 2004- 2006 homicide cases in which the perpetrator was identified, eight perpetrators were known to have drug and alcohol abuse problems. Three perpetrators were known to be victims of child abuse and/or neglect.

Homicides, 1997-2006

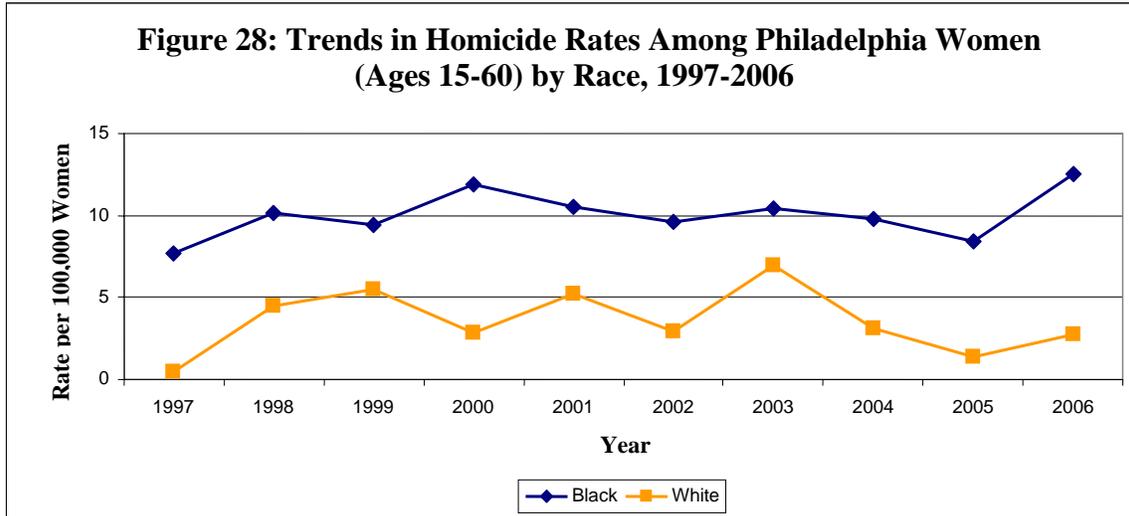
PWDRT reviewed the cases of 358 Philadelphia women who died as a result of homicide between 1997 and 2006.



Source: Philadelphia Vital Statistics 1997-2006, Philadelphia Department of Public Health, n=305. PWDRT identified and reviewed an additional 56 homicides during this time period 1997-2003 and three fewer in 2004-2006. (2006 data are preliminary numbers)

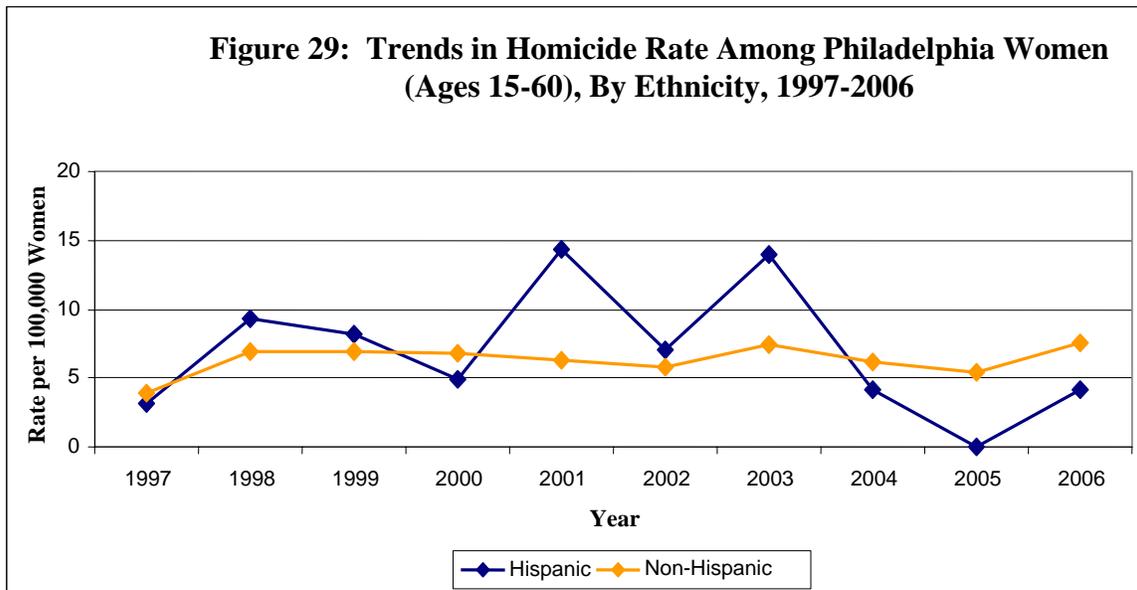
More than one in four homicide victims had a known history of DV (31 percent, n=110). Figure 27 shows the rates of homicide to Philadelphia women during the 10-year time period. The lowest rate was in 1997 (3.9 per 100,000 women) and the highest was in 2003 (8.0 per 100,000 women); overall, the rate during other years was level.

Between 1997 and 2006, the homicide rate was consistently greatest among Black women, compared to both White and Asian women (Figure 28). White women experienced the lowest homicide rate for eight of the 10 years studied, compared to both Black and Asian women.



Source: Philadelphia Vital Statistics 1997-2006, Philadelphia Department of Public Health, n=305. PWDRT identified and reviewed an additional 56 homicides during this time period 1997-2003 and three fewer in 2004-2006. (At the time of this report all reference to 2006 Philadelphia Vital Statistics Report numbers are preliminary data)

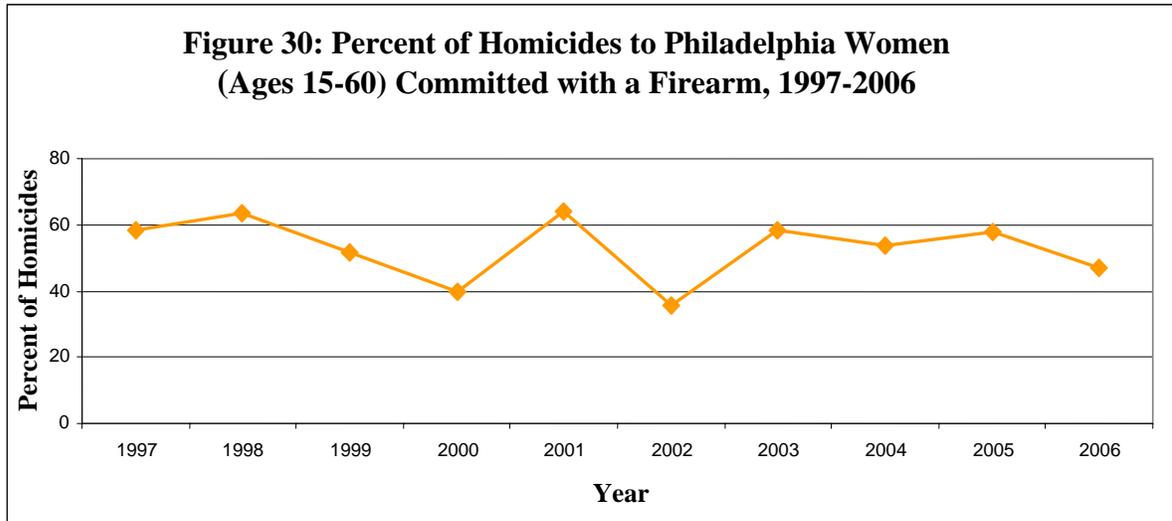
Between 1997 and 2006, Hispanic women experienced a higher homicide rate than Non-Hispanic women during in all but two years (1997 and 2000) (Figure 29)¹².



Source: Philadelphia Vital Statistics 1997-2006, Philadelphia Department of Public Health, n=309. PWDRT reviewed six less homicides between 2004 and 2006. (At the time of this report all reference to 2006 Philadelphia Vital Statistics Report numbers are preliminary data)

¹² The variability of Hispanic homicide rates among Philadelphia women is highlighted by the small Hispanic population of Philadelphia women in this age group, such that each death greatly affects the homicide rate.

Between 1997 and 2006, 241 of all the deaths reviewed deaths were firearm-related (including 185 homicides, 49 suicides and five undetermined deaths). Firearm deaths represent 52 percent of homicides and eight percent of all violence-associated deaths reviewed by PWDRT. Figure 30 shows the percent of homicides committed with a firearm (of any type) between 1997 and 2006.

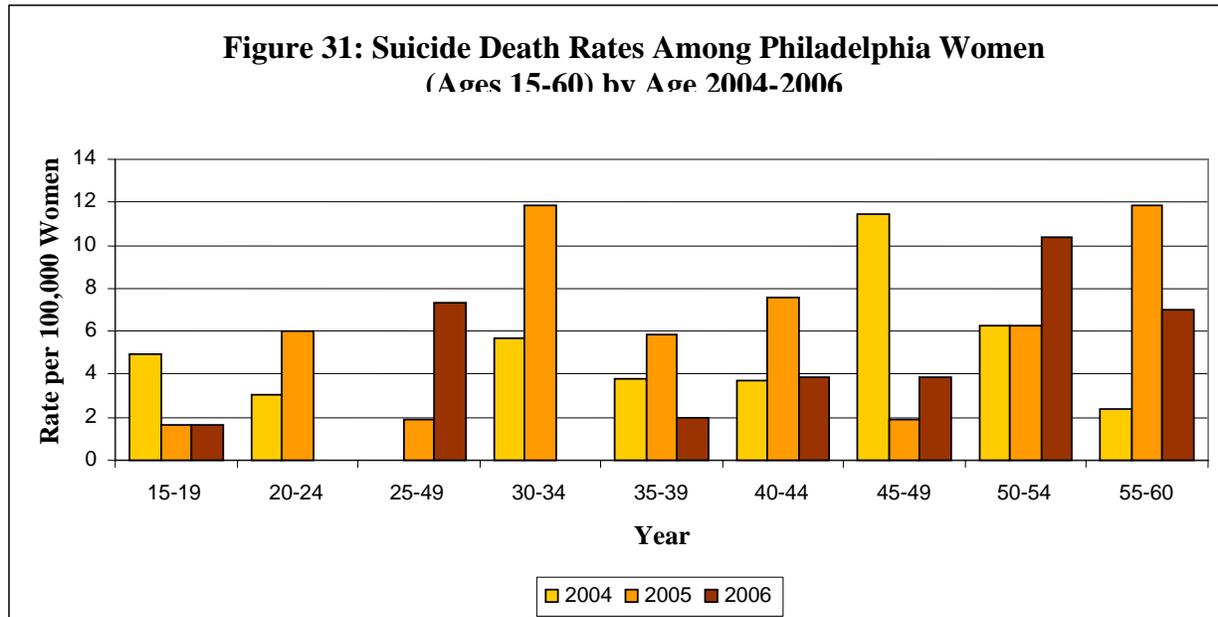


Source : PWDRT data, n=185

VI. Suicides

Suicides, 2004 - 2006

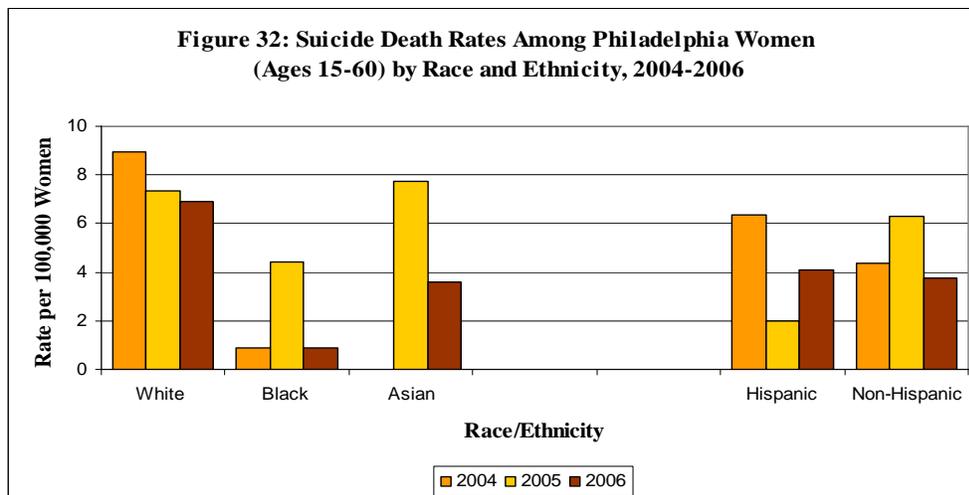
Suicide deaths accounted for two percent of all deaths among Philadelphia women ages 15-60 in 2004 (n=22), 2005 (n=28) and in 2006 (n=18). Due to small numbers, the rates are not useful on their own. The suicide rates fluctuated by year and age. There were no identifiable trends.



Source: Philadelphia Vital Statistics 2004 - 2006, Philadelphia Department of Public Health, n=68. PWDRT reviewed twenty-eight fewer suicides during this time period (n=40). The selection criteria for 2004 and 2005 were different than previous years

The highest suicide rates by age were for women ages 45 - 49 (11.4 per 100,000) in 2004, 30 to 34 (11.8 per 100,000) in 2005, and 50 to 54 (10.4 per 100,000) in 2006.

White women ages 15-60 in Philadelphia had the highest suicide death rates in 2004 through 2006 when compared to women of other races. In 2004, there were no suicide deaths among Asian women in Philadelphia, while there were two in 2005 and one in 2006.

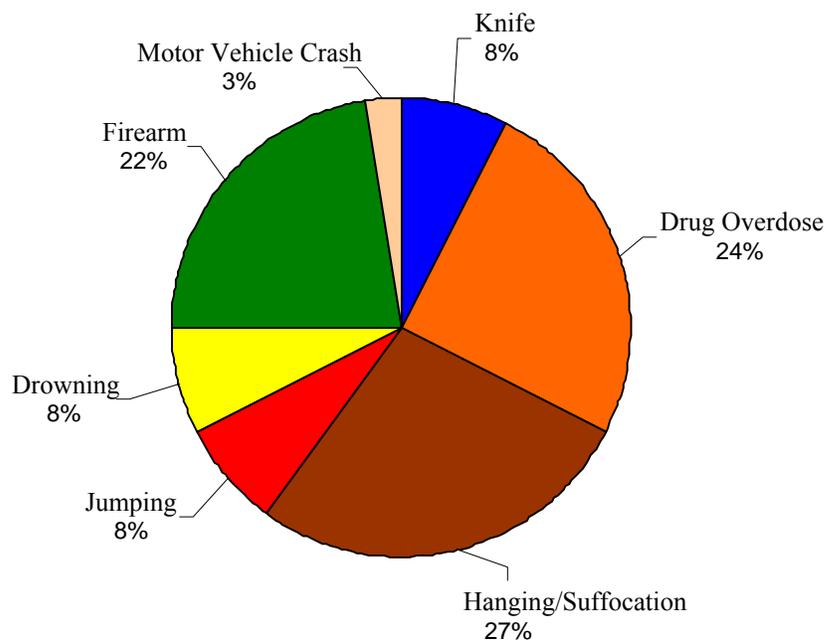


Source: Philadelphia Vital Statistics 2004 - 2006, Philadelphia Department of Public Health, n=68. PWDRT reviewed twenty-eight fewer suicides during this time period (n=40). The selection criteria for 2004 and 2005 were different than previous years.

The suicide rate among Hispanic women in Philadelphia decreased two-fold from 6.37 per 100,000 women in 2004 to 1.99 per 100,000 women in 2005 and went up to 3.74 per 100,000 women in 2006. However, this change may be evident only because of the small number of women in this group, showing more fluctuation between years. The suicide rate among Non-Hispanic women increased only slightly (Figure 32).

PWDRT identified and reviewed 40 suicide deaths among Philadelphia women ages 15-60 between 2004 and 2006. The Team found that 65 percent of suicides occurred in the decedent's home (n=26). Among the cases reviewed by PWDRT, the top two methods/weapons used in suicides were drug overdoses (n=10) and hangings/suffocations (n=10) (Figure 33).

Figure 33: Methods Used in Suicide Deaths Among Philadelphia Women (Ages 15-60), 2004-2006



Source: PWDRT data, n=40

Toxicology investigations were conducted in all 40 suicide cases, and 68 percent had positive findings for either drugs (n=18), alcohol (n=3), or both alcohol and drugs (n=6). Upon review, 27 of these decedents (68 percent) were known to have a history of substance abuse.

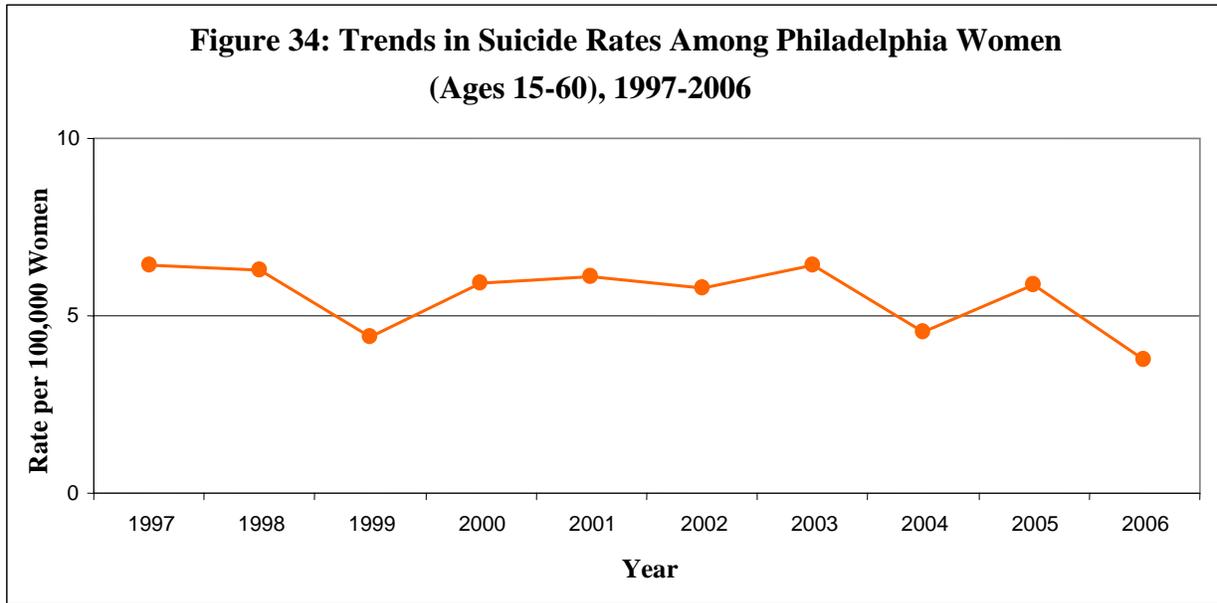
Thirty-five decedents (87 percent) were known by Department of Behavioral Health (CBH & OMH) and/or other agencies because of their mental health history. In eight cases, the decedents were known by CBH to have a history of depression, four were known to be bi-polar and two were known to have an anxiety disorder. In addition, eight of the decedents known to CBH had previously displayed suicidal behaviors. Three decedents of those who died of suicide had attempted suicide previously.

Three of the decedents were known to be victims of child sexual abuse and four had a known history of physical abuse as a child. The Team also found that two of the decedents had a history of prostitution, and that nine of the victims were known by Family Court. Seven women who died by suicide (17 percent) had a known history of DV. Upon review, 12 of the decedents were known to have living children.

Suicides, 1997-2006

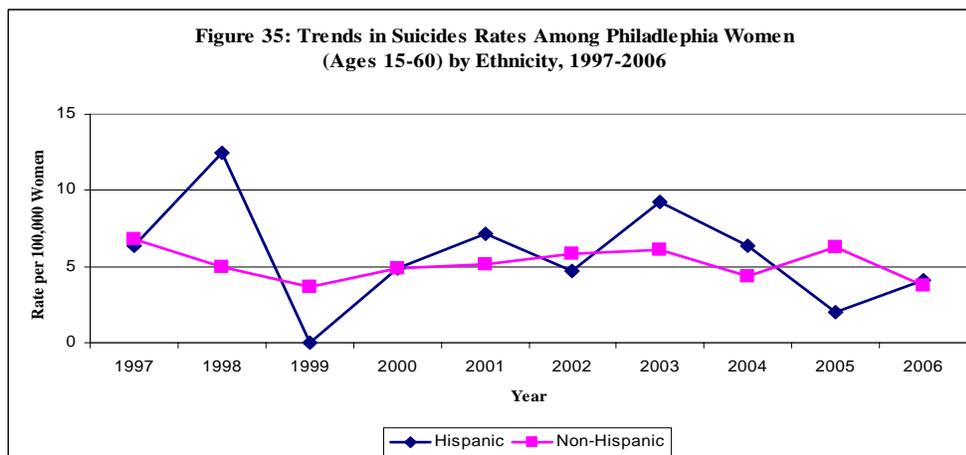
From 1997 to 2006, PWDRT identified and reviewed 236 suicide deaths among Philadelphia women ages 15-60. Suicide deaths accounted for two percent of all deaths among Philadelphia women ages 15-60 from 1997 to 2006 (n=264). Between 1997 and 2006, 20 women (7 percent) who died by suicide had a known history of DV.

The suicide death rate for Philadelphia women ages 15-60 has remained relatively steady over time, with the highest suicide rate of 6.4 per 100,000 in 1997 and slight declines in 1999 and 2006 respectively (4.4 and 3.8 per 100,000 women) (Figure 34).



Source: Philadelphia Vital Statistics 1997-2006, Philadelphia Department of Public Health, n=264. PWDRT reviewed 28 fewer suicides during this time period.

While the overall suicide death rate of Philadelphia women appears to remain constant, there is a fluctuation in Hispanic suicide death rates (Figure 35). However, the fluctuation appears extreme because of the small population size of the Hispanic community of women in this age group. For instance, the suicide rate of Hispanic women peaked at 12.5 deaths per 100,000 Hispanic women in 1998, and dropped to 0.0 deaths per 100,000 Hispanic women in 1999, but these rates represent four suicide deaths in 1998 and zero in 1999.



Source: Philadelphia Vital Statistics 1997-2006, Philadelphia Department of Public Health, n=264. PWDRT reviewed 28 fewer suicides during this time period.

In contrast, Non-Hispanic suicide death rates peaked in 1997 at 6.8 deaths per 100,000 Non-Hispanic women, with a low of 3.7 deaths per 100,000 Non-Hispanic women in 1999; these rates represent 29 and 16 women respectively. Between 2003 and 2005 the rates dropped from 9.1 deaths per 100,000 Hispanic women to 2.0 deaths per 100,000 Hispanic women and increased slightly to 4.1 deaths per 100,000 Hispanic women in 2006.

VII. Undetermined Manners of Death

Undetermined Deaths, 2004 -2006

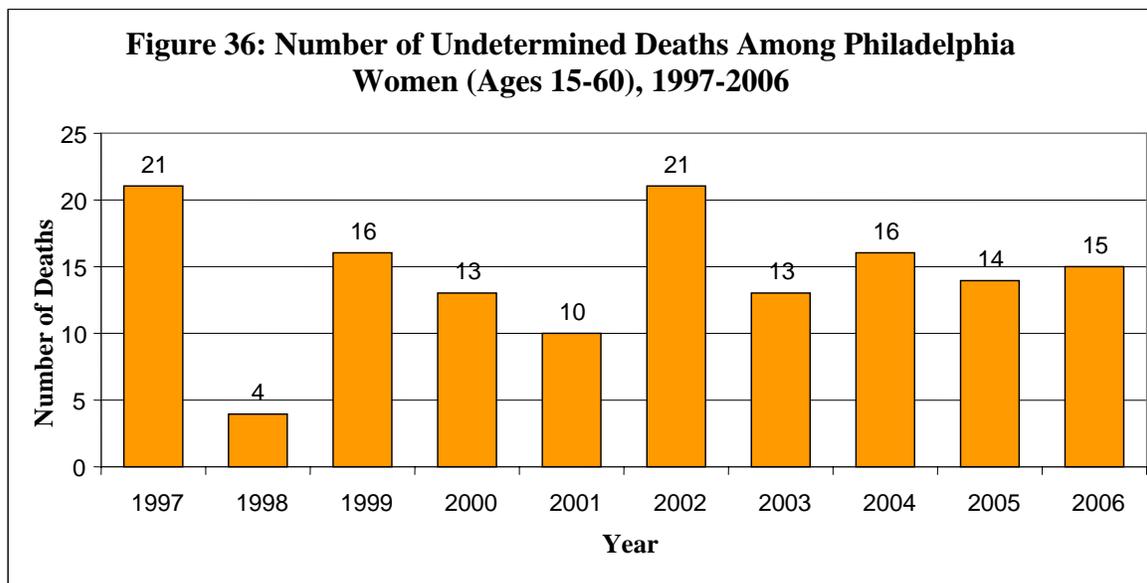
In 2004 through 2006, 58 deaths were classified as an undetermined manner of death by the Office of the Medical Examiner. On some occasions, these may be reclassified as homicide, suicide, or accident death after further investigation.

At the time of reviews and availability of death certificates, PWDRT reviewed 45 of the 58 deaths of Philadelphia women ages 15-60 who died between 2004 and 2006, in which the manner of death was undetermined; these deaths accounted for nine percent of all deaths reviewed. Thirty of the women were White and 12 were Black, and three were Asian or other; all but three were Hispanic.

The most common causes of death listed for these women included long-term effects of drug/alcohol abuse and adverse effects of drug(s) (29 percent, n=13). Twenty-eight of the cases had questionable circumstances¹³, and in one case the decedent was pregnant. Ten women with an undetermined manner of death had a known history of DV (22 percent).

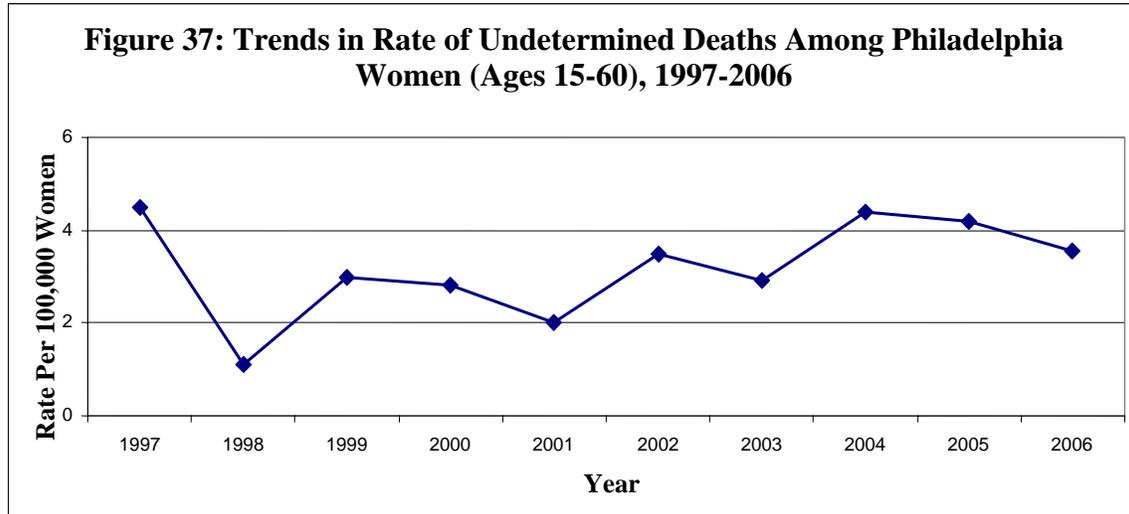
Undetermined Deaths, 1997-2006

Between 1997 and 2006, 153 deaths to Philadelphia women reviewed were classified as undetermined. PWDRT identified and reviewed 143 undetermined deaths to Philadelphia women that occurred during this time period. Figure 36 shows the number of undetermined deaths per year during this time period reviewed by PWDRT. Figure 37 shows the rate of undetermined deaths per year during this time.



¹³ The Clinical Screening Committee determines which cases are considered “questionable,” such as cases in which the manner of death listed on the death certificate is suspected to be incorrect, or cases with particularly uncommon situations. For further discussion, please refer to the Questionable Circumstances section of the report.

Source: PWDRT data 1997-2006, (n=143) PWDRT identified and reviewed three additional undetermined deaths during the 1997-2003 time period



Source: Philadelphia Vital Statistics 1997-2006, Philadelphia Department of Public Health, n=153. PWDRT identified and reviewed ten fewer undetermined deaths during this time period

The two most common causes of death listed for these women were drug related, either long-term effects of drug/alcohol abuse and/or adverse effects of drug(s) (33 percent, n=51). Sixty-six (46 percent) of the undetermined cases had questionable circumstances, and in four cases, the decedent was pregnant. Twenty-four of the women (17 percent) dying with an undetermined manner of death between 1997 and 2006 had a known history of DV. While the differences between average annualized rates of undetermined deaths by zip code are small, for zip codes, see Appendix H, Map 10, for zip codes that experienced undetermined deaths.

Chapter 5. Circumstances of Death: Firearm, Drugs and Alcohol, HIV/AIDS and Questionable Deaths

I. Firearm Deaths

Firearm Deaths, 2004 – 2006

Between 2004 and 2006, 54 deaths reviewed by PWDRT were a result of firearm (40 homicides, nine suicides, three undetermined and two accident deaths). Firearm deaths represent 10 percent of violence-associated deaths reviewed by PWDRT between 2004 and 2006.

PWDRT found that firearms were the predominant weapons used in homicides, accounting for 48 percent (n=40) of the cases, including intimate partner homicides. Half of the cases of intimate partner homicide in 2004 through 2006 were committed using a firearm (42 percent, n=13). Out of the 40 homicide firearm cases, 29 involved handguns, eight involved an unknown firearm type, and three involved a shotgun.

Firearm Deaths, 1997- 2006

Between 1997 and 2006, 241 deaths reviewed by PWDRT involved firearms (including 185 homicides, 49 suicides, 5 undetermined deaths and 2 accident deaths). Firearm deaths represent eight percent of violence-associated deaths reviewed by PWDRT since 1997.

Geographical analysis of lethal firearm use revealed four neighborhoods and zip codes that experienced the highest number of firearm homicide deaths (more than three) to women between 2004 and 2006 (Appendix H, Map 6)

- Logan (19141)
- Nicetown (19140)
- Point Breeze (19145)
- Port Richmond (19134)

II. Drug and/or Alcohol Related Deaths

Research on intimate partner violence and substance abuse shows a significant association between battering incidents and both alcohol and drug abuse (Fals-Stewart, Golden, & Schumacher, 2003). Because of the strong association between violence and drug/alcohol use, PWDRT reviewed deaths of women related to drug and/or alcohol use, including acute and long-term effects. The purpose of this analysis is to identify any history of violence in the lives of these women, as well as any involvement these women may have had with a drug/alcohol treatment program(s) prior to their deaths.

Drug and/or Alcohol Related Deaths, 2004 – 2006

Of the 529 deaths reviewed by PWDRT, 17 percent (n=92) of deaths were at least partially the result of long-term drug and/or alcohol abuse, and 25 percent (n=131) of cases were the result of adverse effects of drugs and/or alcohol. Overall 42 percent (n=223) of the violence associated deaths among Philadelphia women between 2004 and 2006 were related to drugs and/or alcohol.

Illicit substance (36 percent, n=81) were the most common toxicology finding among all these decedents followed by Anti-depressants (26 percent, n=59) and controlled substances (14 percent, n=31). The majority of these women (62 percent, n=139) had a known substance abuse history.

The 223 women who died as a direct result of drug and/or alcohol abuse faced a multitude of mental health problems. Twenty-seven of these decedents (12 percent) had a known history of mental health problems. The most common mental health issues were depression (n=24), suicidal ideation (n=12), and schizophrenia (n=7). Twenty-seven percent (n=61) of these women had a known history of DV.

Deaths Due to Effects of Long-Term Substance Abuse, 2004 – 2006

Between 2004 through 2006, PWDRT reviewed 66 women who died from natural deaths that were caused by the effects of long-term drug and/or alcohol abuse, such as cirrhosis of the liver. The average age of these women was 47 years. Of the 66 cases reviewed, six had a known history of sexual abuse as a child, 22 (33 percent) had a known history of DV; seven were known to have a history of homelessness, and 38 (58 percent) were known to have had a history of and/or treatment for substance abuse. Additionally, 17 (26 percent) were known to the Office of Mental Health.

Deaths Due to Adverse Effects of Drugs, 2004 – 2006

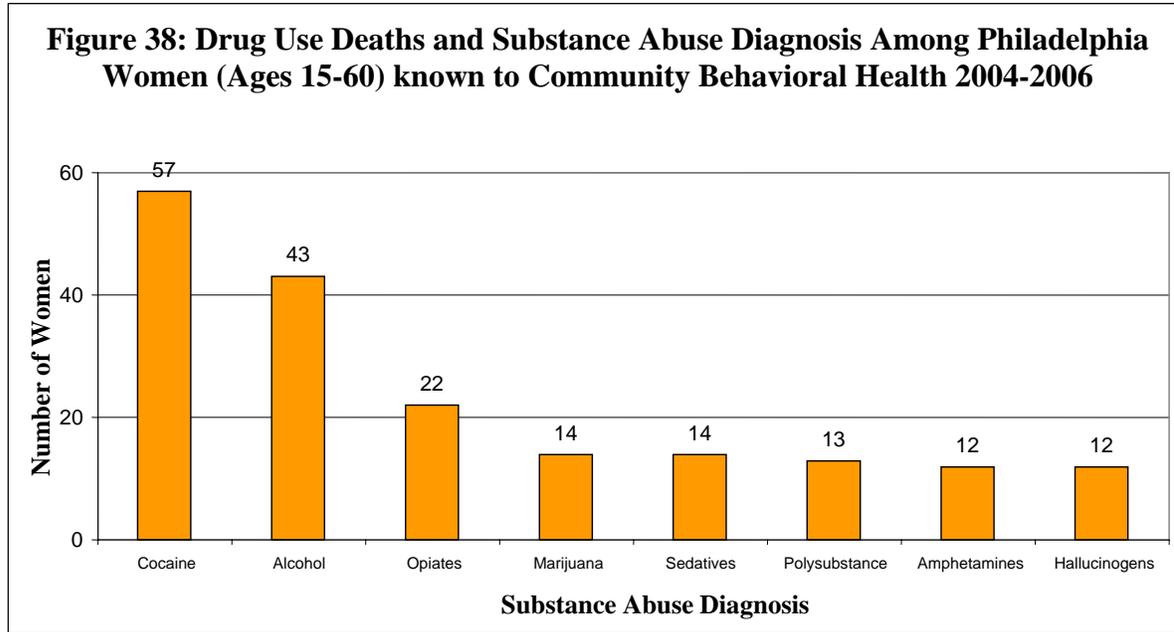
In 2004 - 2006, PWDRT identified 135 women between the ages of 15 and 60 who died from the adverse effects of drugs. The mean age for these women was 40 years. Of the 135 women who died in this manner, 50 percent (n=68) were White, 42 percent (n=57) were Black, and six percent (n=9) was of Other/Unknown race.

Twenty-four percent (n=33) of the women had a known substance abuse problem, 16 percent (n=21) of the women had a known history with criminal justice system prior to their deaths, and 22 percent (n=30) having a known history of prostitution. Additionally, ten percent (n=14) of these women had a known history of mental health problems. Forty (30 percent) of these women had a known history of DV. Eleven percent (n=16) had a known history of physical or sexual child abuse. Three percent of these decedents (n=4) were known to OSH.

History of System Involvement

Of the 223 women who died due to adverse effects or long-term use of drugs and/or alcohol, 26 percent (n=92) were known to have been treated for substance abuse through Community Behavioral Health (CBH). Of those who had a substance abuse history, 87 were approved for treatment services, and 79 of these women utilized the services offered. Of those who utilized treatment services, at least 24 received detoxification services and 21 received rehabilitation services.

Of the 92 women diagnosed by CBH for substance abuse, the most common reported addictions included those for cocaine (n=57), alcohol (n=43), opiates (n=22), polysubstance dependence (n=13), marijuana (n=14), and sedatives (n=12). (Figure 38)



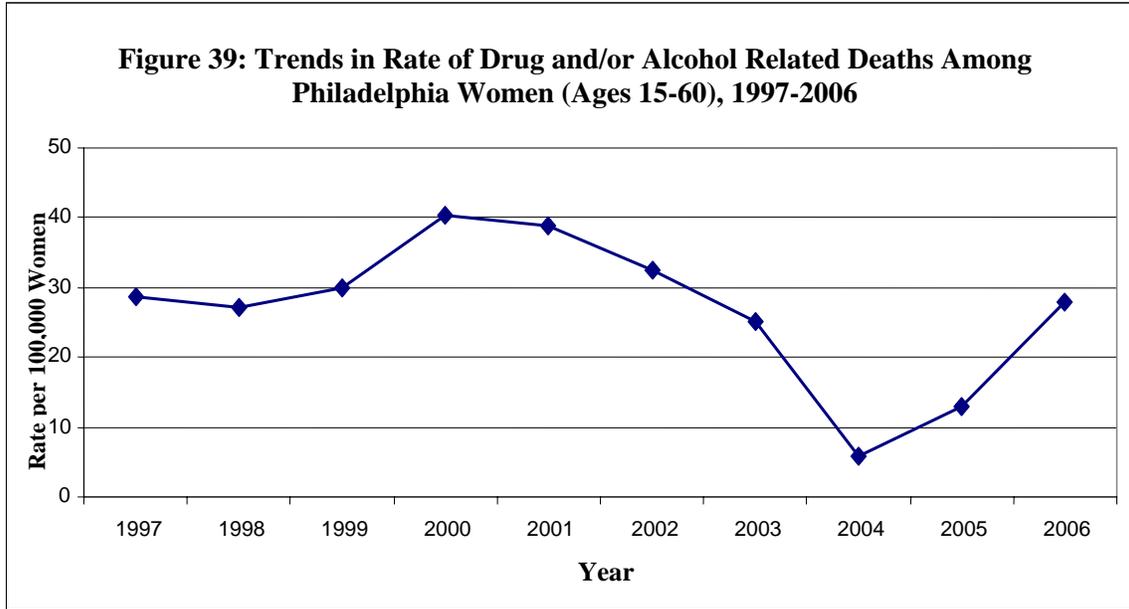
Source: PWDRT data 2004-2006 (n=92) *Note Total is greater than 92 due to multiple addiction diagnosis

The Department of Human Services (DHS) had known 94 of the decedents (42 percent) prior to their deaths: eleven as children, 62 as parents, eight as both a child and a parent, and 12 as another entity. Six of these decedents had active cases at the time of their deaths.

Forty-four decedents (20 percent) were involved with Family Court prior to their deaths and five (2 percent) had obtained a final Protection from Abuse Order (PFA). Furthermore, in one out of three cases (17 percent, n=37) the women had prior involvement with the criminal justice system; 18 women were involved with the system at the time of their deaths, either on bench warrant (n=8), probation/parole (n=9), with an open case, or with a warrant (n=1) issued for their arrest.

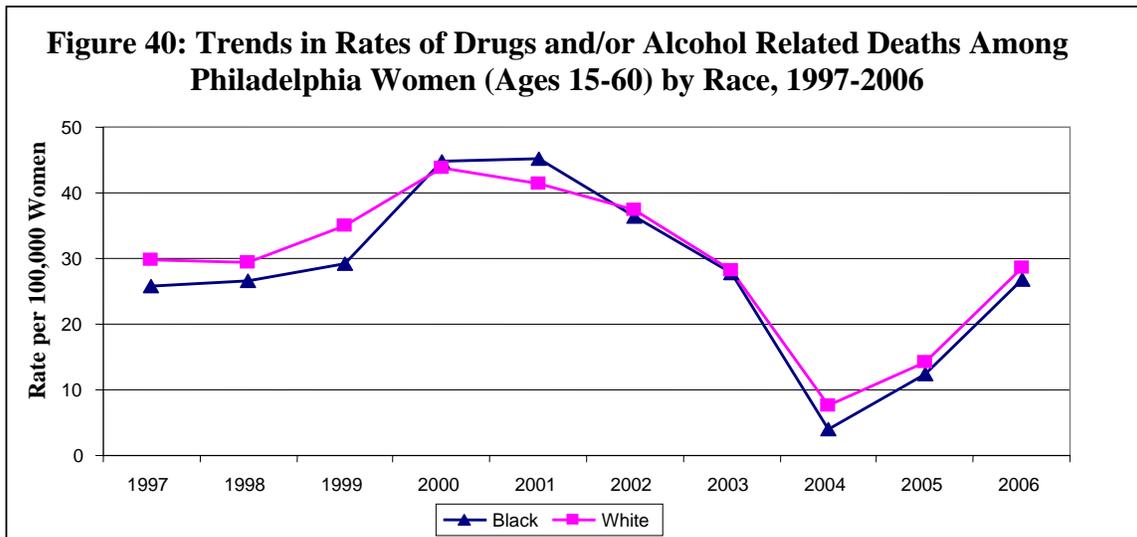
Drug and/or Alcohol Related Deaths, 1997-2006

One thousand twelve hundred and ninety-one women (41 percent) died as a result of drugs and/or alcohol between 1997 and 2006. The number and rates of drug and/or alcohol related deaths of women in Philadelphia have shown increases and decreases between 1997 and 2006, with a peak in 2000 (40.3 deaths per 100,000 women), and a low in 2003 (25.1 deaths per 100,000 women) (Figure 39). 2004 and 2005 rates of drug and/or alcohol related deaths of women in Philadelphia is low due to selection criteria established within those years, which may appear to show a reduced trend for those two years. However, rates of drug and/or alcohol related deaths of women in Philadelphia show an increase in 2006 (27.5 deaths per 100,000 women) from 2003 (25.1 deaths per 100,000 women).



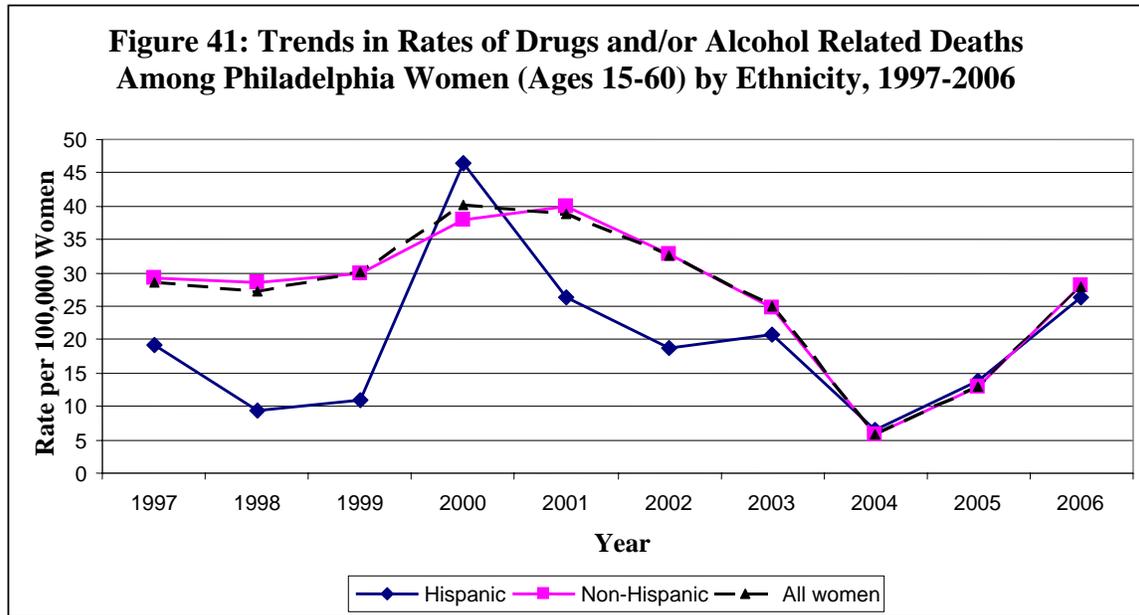
Source: PWDRT data 1997-2006, (n=1,291)

Between 1997 and 2000, White women had a higher rate of drug and/or alcohol related deaths than Black women, except in 2001. The rate of drug and/or alcohol related deaths steadily decreased for both Black and White women between 2002 and 2004. Despite the selection criteria changing for 2004 and 2005 reviews, White women still had a higher rate of death from drug and/or alcohol. (Figure 40)



Source: PWDRT data 1997-2006, (n=1,291)

Both Hispanic and Non-Hispanic women have experienced a decrease in drug and/or alcohol related deaths since 2001, with the decrease in rates for Hispanic women actually beginning in 2000, after peaking. However, comparing 2003 to 2006 shows a slight increase in the rates of both Hispanic and Non-Hispanic women (Figure 41).



Source: PWDRT data 1997-2006, (n=1,291)

* The small number of Hispanic women in the sample causes the trend curve for Non-Hispanic women to match nearly identically with the trend for all women.

Forty-one percent (n=1,291) of the violence-associated deaths among Philadelphia women between 1997 and 2006 were related to drugs and/or alcohol. Twelve percent (n=155) had a known history of DV.

III. HIV/AIDS-Related Deaths

Just as there is a well-documented connection between violence and drug and/or alcohol abuse, so too is there a connection between HIV-positive status and violence. Women who are HIV-positive, or who have AIDS, are more likely to have led violent lives than are HIV-negative women (Wyatt, Myers, Williams, Kitchen, Loeb, Carmona, et al, 2002). IPV contributes to a woman's risk and experience of HIV, as "women may become infected with HIV as a result of forced unprotected sex with an infected individual, or women may be abused as a result of disclosure of positive HIV status" (McDonnell, Gielen, O'Campo, 2003).

HIV/AIDS-Related Deaths, 2004–2006

PWDRT reviewed 62 HIV/AIDS-related deaths occurring between 2004 and 2006¹⁴. PWDRT found that eight (13 percent) of these women had a known history of involvement with prostitution, and 19 (31 percent of HIV/AIDS-related deaths) were known by the Office of Behavioral Health to have substance abuse problems. Thirty-two percent (n=20) of decedents who were HIV-positive or who had AIDS also had a known history of DV.

¹⁴ PWDRT case selection criteria for 2004 and 2005 deaths did not focus on HIV death thus reviewed very few HIV/AIDS deaths.

History of System Involvement

DHS knew 32 of the 2004 - 2006 decedents (51 percent) prior to their deaths: five as children, 21 as parents, one as both a child and as a parent, and five in another capacity. Two decedents had active DHS files when they died.

Ten decedents (16 percent) were known to the Criminal Courts for arrests prior to their deaths; one decedent had open criminal cases at the time of the decedent's death. Additionally, 14 decedents (23 percent) were involved with Family Court prior to their deaths. Sixteen decedents (31 percent) had a known substance abuse history with CBH, and 14 (23 percent) had a known mental health history with CBH.

HIV/AIDS-Related Deaths, 1997-2006

PWDRT reviewed 611 HIV/AIDS-related deaths (18 percent) among Philadelphia women that occurred between 1997 and 2006¹⁵. Ten percent of these women (n=62) had a known history of DV.

IV. Deaths Due to Questionable Circumstances**Deaths Due to Questionable Circumstances, 2004–2006**

The PWDRT Clinical Screening Committee identified 67 deaths occurring between 2004 and 2006 that they believed to have questionable circumstances. Of these, 24 (36 percent) were natural deaths, 15 (22 percent) accident deaths, and 28 (42 percent) deaths were that of an undetermined manner. This is a heterogeneous group of deaths with uncommon situations, including cases in which there may be a suspicion of IPV, or in which there are other irregular circumstances surrounding the cause of death. "Questionable circumstances" included cases for which the Screening Committee suspected the manner of death listed on the death certificate was incorrect, such as "accident" deaths that may have instead been suicides or the result of homicide, or cases in which it was difficult or impossible to accurately assign a manner of death due to the state of decomposition of the body at the time it was discovered.

Upon examination, the decedents reviewed in this cluster appear similar in several ways to the other women reviewed: Eight decedents (12 percent) had a known history of substance abuse. Additionally, eight of these decedents (12 percent) had known involvement with the criminal courts prior to their deaths. Furthermore, twelve of these decedents (18 percent) had been involved with Family Court prior to her death. Twelve women (18 percent) had a history of domestic or intimate partner violence.

Deaths Due to Questionable Circumstances, 1997-2006

Between 1997 and 2006, PWDRT identified and reviewed a total of 440 deaths believed to have questionable circumstances. Forty-five women (10 percent) had a known history of domestic or intimate partner violence.

¹⁵ PWDRT identified and reviewed an additional 42 women who died between 1997 and 2003 who were known to be HIV/AIDS positive. However, HIV/AIDS was not the primary cause of death or review, and these cases are therefore not included in this chapter's discussion.

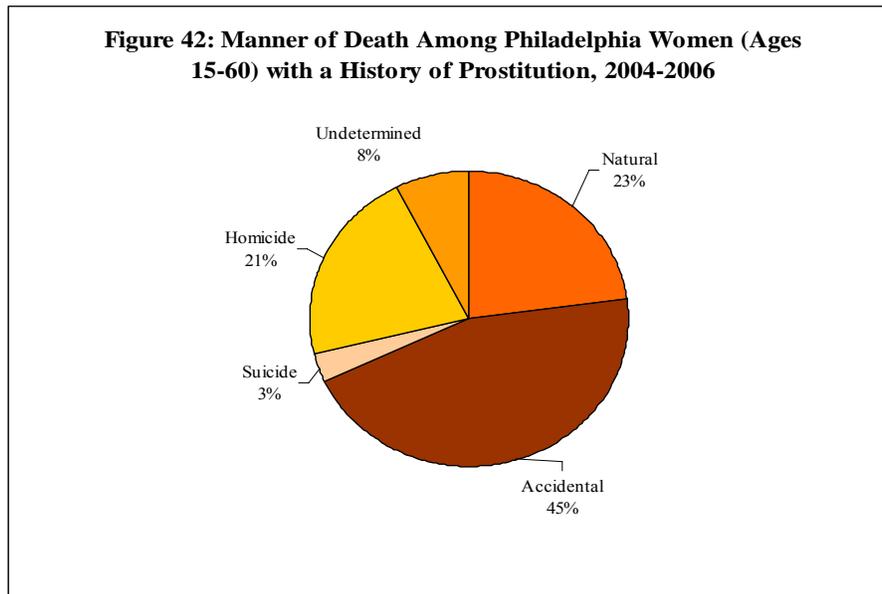
Chapter 6. Life Circumstances: Commercial Sex Work, Homelessness, Immigrant Status, Mental Health and Pregnancy

I. Commercial Sex Work

Women with a history of sex work are among the highest risk population for experiencing violence, violence-related behaviors, and ultimately premature violence-related deaths. Furthermore, sex workers who reported homelessness, substance abuse, and HIV-positive status were even more likely to report lifetime experience of physical and/or sexual abuse.

Decedents with a History of Prostitution, 2004–2006

Twelve percent of the decedents reviewed by PWDRT who died between 2004 and 2006 had a known history of prostitution (n=66). Among these 66 decedents known to have a history of prostitution, 30 died from accident death, 14 died of homicide, 15 died of natural causes, five died of an undetermined manner, and two died by suicide (Figure 47).



Source: PWDRT data 2004-2006, (n=66)

The majority of the women with a known history of prostitution who died between 2004 and 2006 with accident deaths, died as a result of adverse effects of drugs and or long-term drug use and abuse (42 percent, n=28). Toxicology reports indicate that 26 of the 30 women who died of accident death had positive toxicology results for either drugs (67 percent, n= 20), alcohol (3 percent, n=1) or drugs and alcohol (17 percent, n= 5) at the time of their death.

Some of the women who died of natural causes died as a result of long-term drug and alcohol abuse, with causes of death such as cirrhosis, sepsis and liver disease. In addition, women with a

known history of prostitution who died of natural causes also died as a result of HIV/AIDS (n=8). In total, 8 of the 66 decedents with a known history of prostitution were known to have HIV/AIDS (12 percent).

The median age among decedents with a history of prostitution was 40 years of age. The majority of decedents reviewed by PWDRT with a known history of prostitution were Black (58 percent, n=38).

Of the decedents with a history of prostitution, the PWDRT found that 23 had known mental health problems (34 percent) and 36 had a known history of substance abuse (55 percent). PWDRT also found that 22 of the decedents were known to be victims of child physical abuse or neglect (33 percent) and 14 were known to be victims of child sexual abuse (21 percent).

Upon review, the PWDRT found that 92 percent of the decedents were known to the Criminal courts prior to their deaths (n=61). In addition, Family Court knew 31 percent of the decedents prior to their deaths (n=21). The Department of Human Services had contact with 41 of the decedents prior to their deaths (62 percent). Decedents who had a history of prostitution are also known to have had contact with or received services from the following agencies: Lutheran Settlement House, Women Against Abuse Shelter, and Women Against Abuse Shelter Legal Services, Women in Transition, Women Organized Against Rape, the Office of Supportive Housing, and the Office of Mental Health.

Decedents with a History of Prostitution, 1997-2006

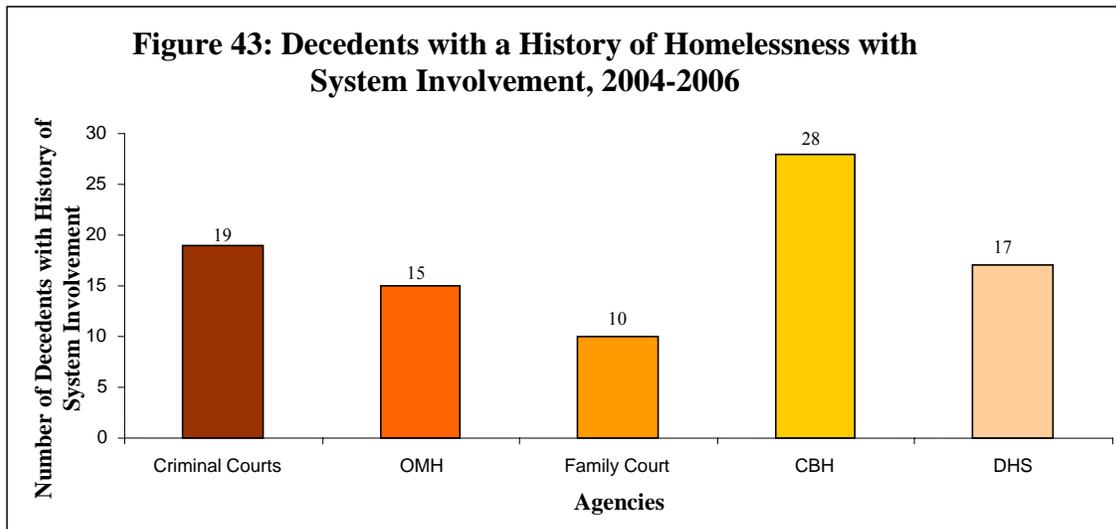
From 1997 through 2006, 11 percent of the decedents reviewed by PWDRT had a known history of prostitution (n=341). From 1997 through 2003, the majority of these decedents with a known history of prostitution died of natural causes. Due to the selection difference for 2004 and 2005, in 2004 through 2006, the majority of these decedents with a known history of prostitution died from accident deaths (n=30) of which 87 percent (n=28) were due to adverse effect of drugs. Natural deaths (n=15) was the second leading manner of death to decedents with a history of prostitution, homicide (n=14) the third manner of death followed by undetermined (n=5) and (n=2) suicide respectively.

II. Homelessness

Homelessness Among Decedents, 2004 – 2006

There is a high prevalence of violence in the lives of homeless women. DV is consistently cited among the primary causes for homelessness; many women leaving in an abusive relationship have nowhere to go (National Coalition for the Homeless, 2005b). Furthermore, homeless women are at an increased risk for experiencing violence, especially while engaging in subsistence services such as the sex trade and panhandling (Wenzel, Leake, & Gelberg, 2001).

PWDRT identified 38 decedents who were known to OSH. The majority of these women were Black (61 percent, n=23) and non-Hispanic (95 percent), and their average age was 40 years. Twelve (31 percent) women died from the adverse effects of drugs, seven (18 percent) from effects of long-term drug/alcohol abuse, another seven (18 percent) from homicide, five (13 percent) women died from HIV/AIDS. Eleven percent (n=4) of the decedents were questionable victims and seven percent (n=3) were from other.



Source: PWDRT data 2004-2006, (n=38)

Seventy-four percent of homeless decedents (n=28) were known to the Office of Behavioral Health. Forty-five percent of homeless decedents (n=17) were known to DHS either as parents child or both prior to their deaths. Forty percent (n=15) were known to the Office of Mental Health. Twenty-six percent (n=10) of women were known to family court and forty-two percent (n=16) of women with a history of homelessness had a known history of DV.

Homelessness Among Decedents, 1997-2006

PWDRT identified 153 decedents who had a history of homelessness and known to OSH between 1997 and 2006. Women with a history of homelessness primarily died from natural (43 percent, n=66) or accident (36 percent, n=55) deaths; 25 women (16 percent) died by homicide, three (2 percent) by suicide, and four (3 percent) of undetermined causes. The majority of these women were Black (67 percent, n=102) and non-Hispanic (97 percent, n=149). Twenty-four percent (n=37) of women with a history of homelessness had a known history of DV.

III. Mental Health History

Mental Health History Among Decedents, 2004–2006

Twenty-six percent of the decedents reviewed by the PWDRT between 2004 and 2006 (n=138) had a history of diagnosis and/or treatment for a mental health condition. Ninety-eight decedents (71 percent) with a known mental health condition were known to Community Behavioral Health's mental health programs. Of the deaths to women who had a history of diagnosis and or treatment for mental health, 28 percent (n=39) were due to the adverse effects of drugs and 12 percent (n=17) were due to the long-term effects of drug and/or alcohol abuse. Additionally, 16 percent (n=22) were homicides, 12 percent (n=17) were suicides, and 13 percent (n=18) had questionable circumstances. Three decedent's deaths were pregnancy-associated, and eight were of other circumstances. Ten percent (n=14) were HIV/AIDS related deaths. Twenty-three percent of the women reviewed in 2004 and 2006 with a known mental health treatment/diagnosis history had a known history of DV.

Fifty-one of the decedents (37 percent) with a known history of mental illness were White, and 74 (53 percent) were Black; decedents with a known history of mental illness were also Asian, Indian, and of unknown/other race at eleven percent (n=15). Nine percent of the decedents were Hispanic (n=13) and 125 (91 percent) were non-Hispanic.

History of System Involvement

PWDRT was able to collect information on mental health diagnoses for a portion of the 98 decedents who had a known mental health history with CBH. Fifty decedents were diagnosed with depression, 14 with bipolar disorder, 18 with schizophrenia, 30 with suicidal ideations, 18 with anxiety disorders, and 18 with another mental health condition. Some decedents had multiple diagnoses.

Women who had a history of a mental health illness are also known to have had contact or received services from the following agencies: Lutheran Settlement House, Women Against Abuse Shelter and Legal Services (all one agency?), Women in Transition, Women Organized Against Rape, Community Legal Services, the Office of Supportive Housing, the Office of Mental Health, Criminal Courts, and the Department of Public Health.

Mental Health History Among Decedents, 1997-2006

Over 600 of the decedents (20 percent) reviewed by the PWDRT between 1997 and 2006 had a history of diagnosis and/or treatment for a mental health condition (n=639). Two-thirds of the decedents with a known mental health history (67 percent, n=431) were known to either CBH or OMH. Mental health conditions can be both the cause and outcome of exposure to violence, and mental health providers can be critical players in breaking the cycle of violence. Nineteen percent of these women (n=124) had a known history of DV at the time of their death.

IV. Pregnancy Associated Death

Physical and sexual violence can have great negative impact on women's sexual and reproductive health. For instance, women experiencing physical and sexual violence are at increased risk for unintended pregnancies, sexually transmitted diseases, or partaking in high-risk behaviors while pregnant (i.e., smoking, or drug and alcohol abuse). The state of pregnancy itself may lead to more violence, although in some cultures, it is likely that pregnancy is a protective state for women (Ellsberg, n.d.). Studies have found that intimate partner homicide is a leading cause of pregnancy-associated maternal death (Horon and Cheng, 2001).

Based on this growing body of literature, PWDRT examined deaths of women that occurred between 1997 and 2006 who were either pregnant at the time of their death or died within a year of giving birth.

PWDRT identified and reviewed the pregnancy-related/associated deaths of 119 Philadelphia women who died between 1997 and 2006. Two-thirds of the women were Black (68 percent, n=81), 27 were White (23 percent), four (3 percent) were Asian, and eight were of other or unknown race (6 percent). The majority of women were non-Hispanic (84 percent, n=100). The average age of women who were pregnant at the time of their death or who died within a year of giving birth was 29.

PWDRT review found pregnancy-associated/related deaths across all manners of death (Table 5).

Table 5: Number of Pregnancy Associated Deaths Among Philadelphia Women (Ages 15-60) by Manner of Death, 1997-2006

Manner of Death	N (%)
Natural	54 (45%)
Unintentional Injury	26 (22%)
Suicide	4 (3%)
Homicide	28 (24%)
Undetermined	7 (6%)

Source: PWDRT n=119

Overall, 15 percent of the women who were either pregnant at the time of their death or died within a year of giving birth (n=18) had a known history of DV. The American College of Obstetricians and Gynecologists recommends routinely screening every pregnant woman for intimate partner violence: at the first prenatal visit, at least once in each trimester, at the postpartum visit, at routine OB/GYN visits, and at preconception visits (CDC, 2006a).

PWDRT is yet unable to collect information as to when specifically violence first occurs to women (before, during, or after pregnancy), whether it continues, and whether it is specifically tied to the state of pregnancy. It would be useful for future analyses of the association between violence and pregnancy if the Team were able to procure this information, as well as to obtain more complete health records as to the number of women who were pregnant in the year prior to their death.

Chapter 7. Child Witnesses and Secondary Victims of Violence

PWDRT examined the number of children affected by intimate partner violence. Previous research indicates that children who witness violence are traumatized, and are more likely to engage in violence as an adult (McNeal and Amato, 1998). Furthermore, these children are more likely to experience developmental difficulties, school failure, and psychiatric disorders; witnessing violence can have both short and long-term consequences on a child's well-being (Nelson, Negron, McKiernan, & Klein, 2004; Groves, 2002). It is estimated that over 3.3 million children witness acts of intimate partner violence each year (American Academy of Pediatrics, 2005). This suggests that many children are at risk for potentially becoming involved in violent relationships as adults because of their traumatic experiences in childhood. In addition, the Adverse Childhood Experiences Study has shown that adverse childhood experiences, such as growing up in a household where the mother is treated violently or a parent is lost during childhood regardless of cause, contributes to a variety of challenges in adult health, including addictive behaviors such as substance abuse and destructive behaviors such as suicide (Felsitic, 2002).

Due to limitations of the data, PWDRT is not yet able to provide an accurate count of the total number of children who lose a mother to violence or who witness a homicide caused by intimate partner violence. However, analysis of the 145 cases from 2004 and 2006 of intimate partner homicide suggests that at least 70 of the decedents had children, at least 18 children lost a mother due to IPV homicide, and at least eight children witnessed an intimate partner homicide.

Similarly, analysis of the 529 deaths of women who died between 2004 and 2006 indicates that at least 187 women were mothers, and at least 476 children had a mother that was reviewed by PWDRT who died a violence-related death in 2004 and 2006. PWDRT identified with certainty at least 18 children who either witnessed the death of a mother, or found her body between 2004 and 2006. More than one-half of these cases involved a homicide (n=15). Between 1997 and 2006, at least 2,011 children, under the age of 18, lost their mother to a violence-associated death.

Chapter 8. Service System Involvement

PWDRT's knowledge of decedent involvement with social, legal, and medical service providers comes directly from PWDRT members representing these city agencies at review meetings. Some of these agencies approve and provide services only to individuals with public insurance, therefore not necessarily capturing the complete extent of services accessed by all decedents. However, analysis of system involvement known to PWDRT can suggest the types of services and agencies most accessed by this population of women who are dying prematurely, identifying best points of intervention to empower women to escape violent relationships and modify risk behaviors.

This section describes some of the services these city agencies provide, along with 10-year trend data (1997-2006) about decedent system involvement.

It is important to recognize that trends of increased use of services might be in part a function of modified reporting systems, such that over the years, service providers have become more detailed in collecting service usage information and reporting it to PWDRT at review meetings.

Community Behavioral Health (CBH)

CBH was launched in 1997 to serve Philadelphia's Medicaid recipients, offering services to individuals with behavioral health issues, including mental health conditions and substance addictions.

PWDRT began collecting information on decedent involvement with CBH in 1997, with more detailed collection beginning in 2000 around approval for, and usage of, mental health and substance abuse services. Between 1997 and 2006, 29 percent of women reviewed by PWDRT (n=924) were known to CBH, either as a service recipient or as a relative to a service recipient. Of the systems and city agencies represented on the Team, the Department of Behavioral Health had contact with the greatest number of decedents between 1997 and 2006.

Behavioral health agencies that address mental health and/or substance abuse should be trained to identify and address IPV issues, understanding that both substance abuse and mental health issues (e.g., suicidal ideation or attempts, depression, anxiety, low self-esteem, etc.) are frequently accompanied by the experience of trauma.

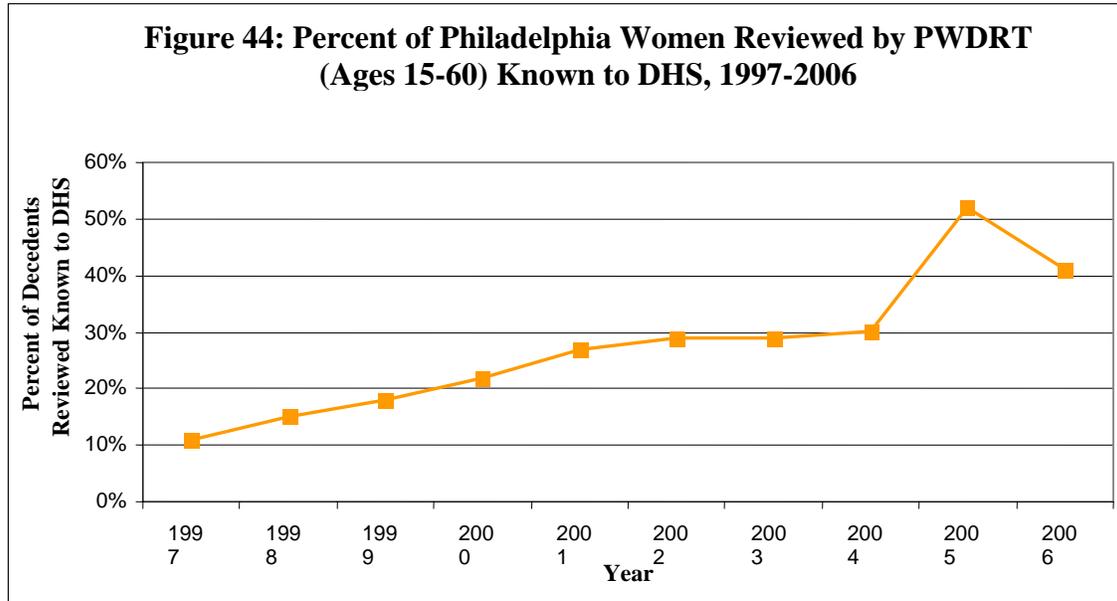
Philadelphia Department of Human Services (DHS)

DHS provides services to children and their families to protect youth from delinquency, and to ensure their safety and stability in a home environment through family preservation or dependency placement. DHS also collaborates with other community agencies to integrate systems to effectively serve children and their families. Of the systems and city agencies represented on the Team, DHS had contact with a significant number of decedents between 1997 and 2006.

PWDRT began collecting information on decedent involvement with DHS beginning in 1997. Women reviewed by PWDRT have been involved with DHS in all capacities--as children, parents, guardians, and relatives. DHS representatives share with the Team information about dependency and delinquency placements of the decedent as a youth, as well as the involvement of her siblings and children with DHS. Between 1997 and 2006, a total of 3,159 women were

reviewed. Of these, 785 (25 percent) were known to DHS. These women were involved with DHS as a child (n=97), parent (n=595), both as a child and as a parent (n=32), or in another capacity (n=61). In 2005, selection criteria were again modified for 2004 deaths.

Since the case selection criteria were refined in 2001 to focus further on violence-related deaths, the percentage of women known to DHS has increased (Figure 49), demonstrating the opportunity for DHS to serve as a point of intervention in the lives of women at risk for violence.



Source: PWDRT data, n= (785)

Criminal Courts

PWDRT began collecting information on the criminal history of both decedents and perpetrators in 1997, including information about the age of first arrest, total number of juvenile and adult arrests, types of crime (e.g., theft, assault, illegal firearms, or drugs) and outcome of the charges (e.g., probation, incarceration, or charges withdrawn).

Many of the victims and perpetrators involved in cases of violent deaths reviewed by PWDRT had a personal and/or family history of violence and delinquency. For instance, 77 percent of perpetrators (n=38) and 24 percent of decedents (n=771) had a known criminal history of prior arrests.

Both juvenile and adult criminal courts can be an important point of intervention by mandating participation in programs such as drug and alcohol counseling and anger management courses.

Family Court, PFA Unit

PWDRT began collecting information on decedent involvement with Philadelphia Family Court Protection From Abuse Orders in 1997. Protection From Abuse orders (PFAs) direct the defendant to stay away from the victim (at home, work, or school), refrain from abusing, threatening, stalking, or harassing the victim, and turn weapons over to the police (Women’s Law Project, 2005).

In 2003, PWDRT began collecting more detailed information (beginning with 2001 data) from the Family Court's PFA unit, which also included the total number of family court cases and Final Order date. PFA filings may be able to add to the Team's understanding of the decedent's role as either a victim or perpetrator in domestic and/or intimate partner violence, helping to pinpoint when a relationship has escalated to life-threatening status. While a PFA cannot prevent all future harm, the act of filing for a PFA is a signal that a woman is likely at elevated risk for violence.

Between 1997 and 2006, PWDRT found that at least 311 (10 percent) of the women reviewed were known to Family Court. Sixty-two (20 percent) of these women received one or more Final PFAs¹⁶.

Office of Supportive Housing

PWDRT began collecting information on decedent usage of OSH in 1997. OSH provides a network of shelters and housing for individuals and families, as well as outreach services, food distribution, and transitional housing. Between 1997 and 2006, 125 (4 percent) PWDRT women accessed OSH services.

Philadelphia Department of Public Health

PWDRT began collecting information on decedent usage of the City health centers in 2003. This information is useful in identifying risk behaviors by examining diagnoses (i.e., sexually transmitted diseases), determining family planning and prenatal care usage, and uncovering preexisting health conditions that may have contributed to the decedent's death. Between 1997 and 2006, at least 156 (5 percent) decedents accessed the City health centers.

Women in Transition (WIT)

WIT provides women with free DV and substance abuse services, including a 24-hour hotline, information and referrals, counseling, and advocacy, so that they can make positive changes in their lives. PWDRT began collecting information on WIT involvement in 1997. Between 1997 and 2006, at least 68 (2 percent) PWDRT decedents accessed WIT.

Women Organized Against Rape (WOAR)

WOAR provides sexual assault counseling and advocacy services. PWDRT began collecting information on decedent involvement with WOAR beginning in 1997. Between 1997 and 2006, 47 (1 percent) PWDRT women accessed WOAR services. In this same time period, rape kits were performed on at least 102 of the decedents, and 24 women were found by the Office of the Medical Examiner to have been sexually assaulted at or shortly before the time of their death.

¹⁶ Once a petition for a PFA has been filed, a judge reviews the petition to determine whether the petition requires a hearing. If so, a temporary order is issued in the interim between the filing and the hearing (usually 10 days or less). The judge then listens to both parties at the hearing and decides whether or not to grant a final PFA, which can be issued for up to 18 months. If the petitioner reconciles with the abuser and allows him/her back into the petitioner's home, the PFA order could be invalidated (Women's Law Project, 2005).

Chapter 9. Policy Recommendations

Through the review process and ongoing meetings of the Policy Committee, PWDRT continues to identify gaps in the systems that serve women in Philadelphia. The following are recommendations from the Philadelphia Women's Death Review Team based on a review of data from 1997 through 2006 and are directed toward the larger Philadelphia community of service providers and advocates.¹⁷ The Team believes these recommendations address the greatest need and have the most potential to reduce trauma and premature death for women and its impact on their children in Philadelphia.

Intimate Partner Violence

Intimate partner homicides accounted for 40 percent of all homicides between 1997 through 2006. Averages of 14 women per year were killed between 1997 through 2006 due to IPV. (See page 23, for more information on IPV).

PWDRT recommends that existing efforts be expanded so that the women experiencing interpersonal violence can be reached at earlier stages of, or prior to, abuse.¹⁸

- Provide anti-violence education and self-defense classes in recreation centers for women, girls and other populations vulnerable to gender-based violence. Develop citywide DV prevention efforts under the leadership of the Mayor that encourage neighbor-to-neighbor networking to reduce isolation and promote community vitality (i.e., Safer Streets – Safer Homes).
- Promote the availability of DV counselors from the advocacy community to be co-located at the PFA filing unit of the Philadelphia Family Court to routinely provide safety planning, information and support to all individuals petitioning the court for protection from abuse and to provide follow-up and outreach services for those whose cases are dismissed through failure to prosecute.
- Strengthen community resources, including emergency shelter space, counseling, and legal advocacy, for those victimized by intimate partner violence.
- Provide anti-violence education through advocacy agencies for women, girls and other populations vulnerable to gender-based violence.
- Implement a comprehensive training program for Probation/Parole staff on issues including: DV; post-traumatic stress disorder; sex worker issues; and women and addiction.
- Develop procedures that accomplish victim safety and intimidation reduction in the court process by adopting a written protocol through the Family Court Administrative Judge to enable court accompaniment by community advocates and support networks to reduce intimidation and ensure safety in the court process.

The American College of Obstetricians and Gynecologists recommends screening every pregnant woman for intimate partner violence at the first prenatal visit, at least once in each trimester and at the postpartum visits (CDC, 2006a).

¹⁷ These recommendations must be viewed within the context of social, economic and community conditions confronting individuals and families. Poverty and low socioeconomic status are often recognized as root causes of violence, though the following recommendations do not focus on these underlying issues. However, increased economic opportunities and continuing education programs for women in neighborhoods at or below the poverty level are critical.

¹⁸ Existing efforts include the launch of the Philadelphia DV Hotline by the City of Philadelphia and the four DV agencies, as well as the DV Task Force convened by the Mayor.

- Promote increased awareness of intimate partner violence among private and public health clinicians and behavioral health providers through teaching hospitals, medical schools and professional medical societies.
- Develop an integrated information system and protocol among Family Court, Criminal Court and law enforcement agencies to identify cases at high risk for violence (i.e., cases where there has been frequent PFA petitions and child custody actions).

PWDRT recommends that every effort be made to increase intervention resources for those individuals who are abusive and commit acts of violence against women and girls.

- Increase the availability of intervention services for abusers by engaging those service providers already working with this population (Menergy, Men's Resource Center) to develop partnerships or additional resources through linkages with community groups (Men United for a Better Philadelphia and fatherhood initiatives) and city agencies such as men's drug treatment centers, mental health providers and prison programs.
- Develop a pilot collaboration between probation officers and the Philadelphia Police Department regarding off-hours visits to high-risk DV probationers.
- Promote judicial education, informing judges about DV and intervention resources in Philadelphia to increase batterer accountability.
- Advocate for the establishment of a public/private-funding stream for batterer intervention programs.

Weapons-related Mortality

Between 1997 and 2006, 241 deaths reviewed by PWDRT involved firearms (including 185 homicides, 49 suicides, five undetermined deaths and two accident deaths). PWDRT found that firearms were the predominant weapons used in homicides, accounting for 48% (n=40) of the cases, including intimate partner homicides. Half of the cases of intimate partner homicide in 2004 through 2006 were committed using a firearm (42 percent, n=13).

In addition, firearms are also used in many violent situations to intimidate and maintain control over a victim or community (see page 50 for more information on firearm violence). Philadelphia has made recent changes in the area of firearm control¹⁹ and PWDRT supports these additional recommendations:

- Promote legislation to decrease gun access, such as efforts to legislate "one gun a month" purchasing restrictions.

Progress: A citywide Weapons-Related Injuries Surveillance System (WRISS) has been implemented to capture all weapons-related injuries (i.e., guns, knives, bats, fists) and develop interventions driven by this data. The Pennsylvania Injury Reporting and Intervention System in Philadelphia provides intensive case management for youth ages 15-24 who have been admitted to three local hospitals for gunshot wounds.

¹⁹ Under the leadership of Mayor Street, State Representatives and State Senators, additional resources and direction have been focused on the issue of firearm use and violent crime. In the last year, several major Philadelphia programs have been announced and/or implemented: the Adolescent Violence Reduction Partnership for 10-15 year olds; Blueprint for a Safer Philadelphia – a 10-year community-based plan, with the goal of eliminating juvenile homicides by 2016; an established firearm court to deal with defendants found with firearms; increased penalties for crimes where firearms are used; support of more detectives to investigate firearm violations; expanded Youth Violence Reduction Partnership. In addition, Governor Rendell signed into law Act 66, which enacts groundbreaking improvements to Pennsylvania's Protection From Abuse Act. This important legislation includes provisions that increase the possible duration of a protection order from 18 months to three years, allow judges to order the relinquishment of all a defendant's firearms while a protection order is in place, give judges authority to order supervised probation of a defendant for indirect criminal contempt of a protection order, and mandate the extension of a protection order upon a finding of contempt for violation of the order.

Substance Abuse

One thousand twelve hundred and ninety-one women (41 percent) died as a result of drugs and/or alcohol between 1997 and 2006. The number and rates of drug and/or alcohol related deaths of women in Philadelphia have shown increases and decreases between 1997 and 2006 (see page 50 for more information about drug and/or alcohol-related deaths). Within this context, PWDRT recommends:

- Applaud the efforts of the Behavioral Health Training and Education Network (BHTEN)²⁰ model for professional staff training and encourage other systems to incorporate similar model of training.
- Promote the inclusion of trauma-focused interventions for chemically dependent women and their children in treatment and recovery programs.
- Encourage collaboration efforts between the Department of Human Services and the Department of Behavioral Health, by providing access to addiction specialists and substance abuse treatment resources for DHS workers to assist in assessing families in which there are possible substance abuse problems.

Commercial Sex Work

From 1997 through 2006, 11 percent of the decedents reviewed by PWDRT had a known history of prostitution (n=341). From 1997 through 2003, the majority of these decedents with a known history of prostitution died of natural causes. Due to the selection criteria difference for 2004 and 2005, the number of natural violence-associated deaths of women (ages 15-60) was reduced. Between 2004 and 2006 twelve percent of the decedents reviewed by PWDRT who died had a known history of prostitution (n=66).

PWDRT has been committed to supporting the work of the Sex Workers Health and Safety Task Force (SWHSTF) and recommends:

- Identify a community agency to provide leadership and resources to coordinate the efforts of SWHSTF

Access to Information and Coordination

- Expand capacity in prioritizing coordinated training programs for professionals in the fields of mental health, child welfare, education, health, homelessness and public housing systems regarding the impact of trauma, DV and substance abuse on women.

Progress: Lutheran Settlement House has a specific training program targeting professional service providers that is currently being conducted bi-monthly; Women in Transition, Inc., Women Against Abuse, Congreso de Latinos Unidos, and Women Organized Against Rape also provide a similar variety of such trainings.

- Expand capacity of crisis treatment centers for children and youth to provide appropriate trauma intervention and treatment to children under the age of five and above the age of 14 because they remain underserved age groups.
- Centralize the DV and Special Victims Units within the Police Department to ensure that: (1) victims and perpetrators are not lost as they move from one district to another; (2) there is standardization and oversight of police response to DV calls including how calls are coded.

²⁰ BHTEN has a continuing commitment to provide professional training about the impact of trauma and DV on women and its relationship to drugs and/or alcohol.

- Expand literacy levels for all materials developed for use at court and in agencies by developing educational resources that are both cultural and literacy appropriate to address to needs of families being served.

Child Witnesses to Violence

Over the ten-year period, 1997 to 2006, at least 2,011 children lost their mother to a violence-related premature death. Between 2004 and 2006, data indicate that at least 187 women reviewed were mothers, and approximately 476 children had a mother that was reviewed by PWDRT who died as a result of a violence-related death. PWDRT identified with certainty at least 18 children who either witnessed the death of a mother, or found her body between 2004 and 2006. Almost all of these cases involved a homicide (n=15).

- Develop a protocol within the Police Department to automatically refer all children who have experienced the death of a parent or witnessed a traumatic event to trauma assistance services.
- Promote outreach in schools, community and family centers, and faith-based organizations for children who witness violence.
- Expand crisis treatment centers to provide appropriate trauma intervention and treatment to children under the age of 19.

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Appendix A – Membership List

<ul style="list-style-type: none"> ▪ Anti–Violence Partnership of Philadelphia <ul style="list-style-type: none"> ▫ Families of Murder Victims 	<ul style="list-style-type: none"> ▪ Philadelphia Family Court <ul style="list-style-type: none"> ▫ Adult Probation and Parole Department ▫ Family Court Division – Domestic Violence Unit
<ul style="list-style-type: none"> ▪ Children’s Crisis Treatment Center <ul style="list-style-type: none"> ▫ Trauma Assistance Program 	<ul style="list-style-type: none"> ▪ Philadelphia Department of Human Services <ul style="list-style-type: none"> ▫ Children and Youth Division
<ul style="list-style-type: none"> ▪ Congreso de Latinos Unidos, Inc. 	<ul style="list-style-type: none"> ▪ Philadelphia Department of Public Health <ul style="list-style-type: none"> ▫ The Division of Maternal, Child and Family Health
<ul style="list-style-type: none"> ▪ Philadelphia’s District Attorney Office 	<ul style="list-style-type: none"> ▪ Philadelphia Health Management Corporation <ul style="list-style-type: none"> ▫ Research and Evaluation ▫ Public Health Consultant
<ul style="list-style-type: none"> ▪ Drexel University School of Public Health 	<ul style="list-style-type: none"> ▪ Philadelphia Legal Assistance
<ul style="list-style-type: none"> ▪ Federal Bureau of Investigation 	<ul style="list-style-type: none"> ▪ Philadelphia Police Department <ul style="list-style-type: none"> ▫ Homicide Unit ▫ Special Victims Unit
<ul style="list-style-type: none"> ▪ Grief Assistance Program, Inc. 	<ul style="list-style-type: none"> ▪ Temple University School of Medicine
<ul style="list-style-type: none"> ▪ Lutheran Settlement House <ul style="list-style-type: none"> ▫ Bilingual Domestic Violence Project 	<ul style="list-style-type: none"> ▪ Women Against Abuse
<ul style="list-style-type: none"> ▪ Office of Emergency Shelter and Services 	<ul style="list-style-type: none"> ▪ Women In Transition
<ul style="list-style-type: none"> ▪ Medical Examiner’s Office 	<ul style="list-style-type: none"> ▪ Women Organized Against Rape
<ul style="list-style-type: none"> ▪ Philadelphia Department of Behavioral Health/Mental Retardation Services <ul style="list-style-type: none"> ▫ Community Behavioral Health ▫ Office of Mental Health 	<ul style="list-style-type: none"> ▪ Women’s Law Project

Appendix B – Confidentiality Statement

**CONFIDENTIALITY STATEMENT FOR THE PHILADELPHIA WOMEN’S DEATH
REVIEW TEAM**

As a member of Philadelphia Women’s Death Review Team, I understand that the purpose of the review is to identify databased strategies to reduce the incidence of violence or abuse-related and maternal mortality deaths among Philadelphia women.

I understand that all information including, but not limited to, photographs, x-rays, oral or written summaries, discussions, opinions, impressions or accounts or any other data to be reviewed in the course of these Team meetings is strictly confidential, and that this information shall not be discussed outside of the Team meeting. This information shall not be discussed with any person or agency member who is not a Team member and who has not signed this Confidentiality Agreement.

I understand that any person who willfully releases or permits to be released any information reviewed and or discussed in any Team meeting shall be subject to criminal and civil liability for breach of confidentiality.

I understand that all information reviewed in these series of Team meetings is strictly confidential and is made available to me solely based on my status as an active member of this Team. My signature below acknowledges that I have read and understand this statement and that I will not disclose any information discussed at any Team meeting.

Print Name: _____

Signature: _____ Date: _____

Organization: _____

Address: _____

Telephone: _____ Fax: _____

Email: _____

Appendix C – Data Collection Form

Death Certificate Information

Review Date: (MM/DD/YY) _____

1. MEO#: _____

2. Last Name: _____

3. First Name: _____

4. Alias: _____

5. Name of Spouse: _____

6. Age: _____

7. Sex: 1. Male 2. Female

8. Gender identity:
1. Known 2. Suspected 3. Unknown

8a. Identification:
1. Man 2. Woman

9. Sexual attraction (orientation):
1. Known 2. Suspected 3. Unknown

9a. (orientation) :
a. heterosexual b. lesbian
c. gay c. bisexual
d. questioning

10. DOB: _____

11. Country of birth if not USA: _____

12. DOD: _____

13. Address: (place of residence)
Street: _____

City: _____

State: _____

Zip: _____

14. Religion: _____

16. Ethnicity:
1. Hispanic 2. Non-Hispanic

17. Race:
1. Caucasian 4. Native Am.
2. Black 98. Other
3. Asian 99. Unknown

18. Marital Status:
1. Never Married 4. Divorced
2. Married 5. Widowed
3. Separated 99. Unknown

19. Relationship status
1. Single
2. Same sex domestic partnership
3. Opposite sex domestic partnership

20. Employed?
1. Yes 99. Unknown
2. No

21. Place of employment: _____

22. Education level:
1. Less than H.S. 4. Post H.S.
2. Some H.S. 98. Other _____
3. H.S. graduate 99. Unknown

23. Highest grade completed: _____

24. Manner of Death:
1. Natural 4. Homicide
2. Accidental 5. Undetermined

3. Suicide 6. Pending

25. Place of Death: _____

26. Reason for Review:
 AIDS/HIV
 Effects of long-term D/A abuse
 Adverse effect of drug(s)
 Questionable circumstances
 Homicide
 Suicide
 Pregnancy Associated
 Other

27. Primary cause of death (as listed on certificate): _____

28. Underlying cause of death (as listed on certificate): _____

29. Contributing factors of Death: _____

XX. Did Tobacco Use Contribute to Death?

Yes Probably
 No Unknown

30. Address of Event:

Street: _____

City: _____

State: _____

Zip: _____

31. Date of event: _____

32. Approx. time of event: _____

33. Certifier:
 MD
 ME

34. Autopsy performed?
1. Yes
2. No
99. Unknown

35. Was there a problem with the death cert?
1. Yes
2. No
99. Unknown

36. Problem with death certificate:
 Manner Certifier
 Cause Not applicable
 Circumstance Other

37. Was there a death scene investigation?:
1. Yes
2. No
3. Unknown

38. Death known from:
 Death certificate
 PA Health Dept
 MEO
 DA's office

XX. Was the decedent:

- Pregnant within the past year
- Pregnant at the time of death
- Not pregnant, but pregnant within 42 days of death

MEO

39. Place of event:

- | | |
|-----------------------|--------------------|
| 1. Highway/street | 10. Vehicle |
| 2. Own residence | 12. Restaurant |
| 3. Other residence | 13. Childcare |
| 5. Victim's workplace | 14. Hosp. /N. home |
| 6. Bar/club/tavern | 16. Train tracks |
| 7. Recreation area | 19. Vacant Lot |
| | 98. Other |
| | 99. Unknown |

40. If a residence, was it a known drug house?

41. Evidence of prior body related injury?

42. Comorbidities:

- | | |
|--|---|
| <u>Physical</u> | <u>Mental</u> |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anxiety disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mood disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cognitive disorder |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> D/A disorder |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hypertension | |
| <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Obesity | |

43. Was there a toxicology investigation?

- | | |
|-----|---------|
| 1. | Yes |
| 2. | No |
| 99. | Unknown |

44. Toxicology findings:

- | | |
|--|---------|
| 1. Alcohol | 3. Both |
| 2. Drugs | 4. None |
| 5. Positive, b/c of hospital/EMS meds or prescription meds at appropriate dosage | |
| 99. Tox not in file | |

- Not pregnant, but pregnant 43 days to 1 year before death
- Unknown if pregnant within the past year

45. Drug type(s):

- | | |
|---|--|
| <input type="checkbox"/> Anti-convulsants | <input type="checkbox"/> Sleeping pills |
| <input type="checkbox"/> Controlled Substnc. | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Anti-depressants | <input type="checkbox"/> Pain meds |
| <input type="checkbox"/> Antipsychotics | <input type="checkbox"/> Illicit substance |
| <input type="checkbox"/> Over the Counter _____ | |

46. If yes, illicit substance, which:

- | | |
|--|--|
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Amphetamines |
| <input type="checkbox"/> Crack/Cocaine | <input type="checkbox"/> Sedatives/hypnotics |
| <input type="checkbox"/> Heroin | <input type="checkbox"/> Hallucinogens |
| <input type="checkbox"/> Benzos | <input type="checkbox"/> Other |

48. If pregnant at time of death:

Weeks gestation: _____

50. Was a rape kit performed/smear and swabs taken?

- | | |
|-----|---------|
| 3. | Yes |
| 4. | No |
| 99. | Unknown |

51. Evidence of recent sexual activity?

- | | |
|---------------------|-------------|
| 1. Prob. Rape | 3. No |
| 2. Prob. Consensual | 99. Unknown |

52. Type of weapon/means used

(check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> shotgun | <input type="checkbox"/> drowning |
| <input type="checkbox"/> rifle | <input type="checkbox"/> poisoning by gas |
| <input type="checkbox"/> knife | <input type="checkbox"/> Belt/strangulate |
| <input type="checkbox"/> fists/hands/feet | <input type="checkbox"/> Gun type unkn |
| <input type="checkbox"/> fire | <input type="checkbox"/> Blunt force object |
| <input type="checkbox"/> poison (drug) | <input type="checkbox"/> handgun |
| <input type="checkbox"/> hang/suffocation | <input type="checkbox"/> Other |
| <input type="checkbox"/> jumping | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> electrocution | |

XX. Electricity or heat on at Time of Event?

- | | |
|--------|-------------|
| 1. Yes | 97. N/A |
| 2.No | 99. Unknown |

Contact with DHS

54. Decedent known to DHS prior to her death?

- 1. as a child
- 2. as a parent
- 3. as both
- 4. not known
- 98. as other
- 99. Unknown

54a. Year the DHS first got involved: _____

55. Were there prior reports of abuse?

- 1. Yes
- 2. No
- 98. Other
- 99. Unknown

55a. # of substantiated _____

55b. # of unsubstantiated _____

56. What was the nature of DHS involvement?

(Check all that apply)

- Investigation/assessment services of Child Protective Services or General Protective Services reports
- In home services child protection (SCOH)
- Prevention Services
- Dependent placement services
- Delinquent placement services

57. Was this an active file?

58. If active, was DHS notified of decedent death?

- 1. Yes
- 2. No
- 99. Unknown

59. Date file closed: _____:

60A. Total number of living children _____

60B. Did decedent have living children (< 18)?

- 1. Yes
- 2. No
- 99. Unknown

60C. Total number of living children <18 _____

62. Were children placed as a result of this death?

- 1. Yes
- 2. No
- 99. Unknown

If yes, with whom? _____

SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT INFORMATION

Substance Abuse

110. Does the decedent have a substance abuse history with CBH?

- 1. Yes
- 2. No
- 99. Unknown

111. Was the decedent approved for SAT services?

- 1. Yes
- 2. No
- 99. Unknown

112. Did the decedent utilize SAT services?

- 1. Yes
- 2. No
- 99. Unknown

113. SA Treatment type:

- Outpatient
- Intensive outpatient
- Halfway
- Non-hospital short-term res(rehab)
- Non-hospital long-term res (rehab)
- Hospital based residential tx
- Detoxification
- Unknown

114. Substance abuse diagnosis

- Alcohol
- Amphetamines
- Cocaine
- Hallucinogens
- Inhalants
- Sedatives/hypnotics
- Opiates
- Substance Dependence (Polysubstance)
- Marijuana

115. Date of most recent discharge from SAT, if known: _____

119. Number of detox authorizations: _____

120. Number of rehab authorizations: _____

116. Number of days authorized for SAT: _____

Mental Health

120. Does the decedent have a mental health history with CBH?

- 1. Yes
- 2. No
- 99. Unknown

121. Was the decedent approved for MH services?

- 1. Yes
- 2. No
- 99. Unknown

123. MH treatment type:

- Inpatient Partial hospital
- Outpatient Residential
- Unknown

124. Mental health diagnosis:

- Depression
- Bipolar
- Schizophrenia
- Anxiety disorder
- Suicidal
- Other _____

125. Date of most recent discharge from mental health treatment:

126. Number of days authorized for mental health treatment:

CRIMINAL JUSTICE

Homicide

65. Was the homicide random?

- 1. Yes
- 2. No
- 3. Unknown

66. Has the perpetrator(s) been identified?

- 1. Yes
- 2. No
- 99. Unknown

67. Number of perpetrators: _____

68. Relationship of Perpetrator to victim:

- 1. Parent / guardian
- 3. Spouse / paramour
- 4. Ex-partner
- 7. Friend
- 8. Acquaintance
- 10. Stranger
- 14. Other relative
- 15. Children
- 98. Other
- 99. Unknown

69. Circumstances:

- 1. IPV
- 2. Felony (other)
- 3. Arson
- 4. Gang activity
- 5. Crossfire
- 6. Argument general
- 98. Other
- 99. Unknown

70. Motive:

- 1. Argument (general)
- 2. Decedent ending Relationship
- 3. Retaliation
- 4. Custody battle
- 5. Self-defense
- 6. Drug-related
- 98. Other
- 99. Unknown

71. Other persons/victims injured?

- 1. Yes
- 2. No
- 99. Unknown

72. How many? _____

75. Children witness the death or find the body?

- 1. Yes
- 2. No
- 99. Unknown

76. Were services provided to child witnesses?

- 1. Yes
- 2. No
- 99. Unknown

77 Was the Trauma Referral Hotline Contacted?

- 1. Yes
- 2. No
- 99. Unknown

78. Calls made to 911 in year prior to death?

- 1. Yes
- 2. No
- 99. Unknown

Decedent Criminal Record

73. Decedent's legal status with justice system at time of event

- 1. Bench warrant
- 2. Probation/parole
- 3. Arrest warrant
- 4. Completed
- 5. Incarcerated
- 6. Open case
- 7. No record
- 8. Unknown

74. Decedent Adult record:

Charge	#arrests	#convict	#incarc	#probat
Drug-related				
Property				
Prostitution				
Sex Offenses				
Theft				
Violence				
Weapons				
Other				

Suicide/Suicidal Ideation

80. Previous suicide attempt(s)?

- 1. Yes
- 2. No
- 3. 99. Unknown

81. Number of previous suicide attempts: ____

82. Was suicide note left?

- 4. Yes
- 5. No
- 99. Unknown

XX. Suicidal behaviors preceding the death?

- 1. Suicidal ideation
- 2. Specific plans
- 3. Attempts made, no medical attention necessary
- 4. Attempts made, medical attention necessary
- 5. None of the above
- 99. Unknown

Decedent Personal and Family History**63. Decedent (D)/Family (F) history:**

1. Diagnosis/treatment for MH/MR	D	F
4. Vict. child abuse/neglect-phys.	D	F
5. Vict. child abuse- sexual	D	F
7. Perp child abuse/neglect	D	F
18. Prior reports to PD sex. assault	D	F
8. Hist/Treat for substance abuse	D	F
9. Prior arrests/dispositions/convict.	D	F
15. Homeless – ever	D	F
17. Lost friend/family to violence/suicide	D	F
13. CBO contact	D	F
14. Homeless – currently	D	F
19. History of prostitution	D	F
20. Victim of DV	D	F
21. Perpetrator of DV	D	F

64. Decedent received services/in contact with:

1. Lutheran Settlement House	Y	N
2. Congreso	Y	N
3. Women In Transition	Y	N
4. WAA legal Center	Y	N
5. WOAR	Y	N
6. Community legal services	Y	N
7. WAA shelter	Y	N
8. Emergency Shelter Svc (OESS)	Y	N
9. Comm Behavioral Health (CBH)	Y	N
10. Office Mental Health (OMH)	Y	N
11. Health Department/Health Centers	Y	N
12. Criminal Courts	Y	N
13. Family Court, PFA Unit	Y	N
14. DHS	Y	N
15. Other agency	Y	N
16. DV Hotline contact	Y	N

Perpetrator Information

83. Did decedent live with perpetrator at any time in the year prior to death?

- 1. Full time
- 2. Part time
- 4. Not at all
- 99. Unknown

83B. Did decedent live with perpetrator at the time of event?

- 1. Yes
- 2. No
- 3. 99. Unknown

83c. Did decedent live alone at the time of event?

- 1. Yes
- 2. No
- 99. Unknown

84. Was the perpetrator the father of decedent's children?

- 3. Yes
- 4. No
- 99. Unknown

85. Name: _____

86. Address: _____

87. City: _____ **88. State:** _____

89. Zip: _____ **90. Age:** _____

91. Gender:

- 1. Male
- 2. Female
- 99. Unknown

92. Race:

- 1. Caucasian
- 2. Af.-American
- 3. Asian
- 4. Native American
- 98. Other
- 99. Unknown

93. Ethnicity:

- 1. Hispanic
- 2. Non-Hispanic

94. Has child/children in his/her custody?

- 1. Yes
- 2. No
- 99. Unknown

95. On disability?

- 1. Yes
- 2. No
- 99. Unknown

96. Employed:

- 1. Yes
- 2. No
- 99. Unknown

97. Toxicology investigation performed?

- 1. Yes
- 2. No
- 99. Unknown

98. Toxicology findings:

- 1. Alcohol
- 2. Drugs
- 3. Both
- 4. None

99. Drug type:

- 1. Anti-convulsants
- 5. Sleeping pills

- 2. Anti-depressants
- 3. Anti-psychotics
- 4. Controlled substance
- 6. Pain meds
- 7. Illicit substance
- 8. Other: _____

100. Did perpetrator commit suicide?

- 1. Yes
- 2. Attempted
- 3. No
- 99. Unknown

101. Perpetrator (P)/Family (F) History:

- 1. Diagnosis/treatmnt for mh/mr P F
- 4. Vict. child abuse/neglect-phys. P F
- 5. Vict. child abuse- sexual P F
- 7. Perp child abuse/neglect P F
- 18. Prior reports to PD sex. assault P F
- 6. Prior reports DHS child abuse/neglect P F
- 8. Treatment for substance abuse P F
- 9. Prior arrest/disposit/convict. P F
- 10. Contributing medical problems P F
- 12. Employment problems P F
- 16. Frequent moves P F
- 19. Lost friend/family to violence P F
- 13. CBO contact P F
- 14. Homeless – currently P F
- . History of prostitution P F
-) 15. Homeless – ever P F

102. At time of event, perp. current legal status:

- 1. Bench warrant
- 2. Probation/parole
- 3. Arrest warrant
- 4. Completed
- 5. Incarcerated
- 6. Open case
- 7. No record
- 99. Unknown

103. Perpetrator Adult record:

Charge	#arrests	#convict	#incarc	#probat
Drug-related				
Property				
Prostitution				
Sex Offenses				
Theft				
Violence				
Weapons				
Other				

104. Perpetrator juvenile record:

Charge	#arrests	#convict	#incarc	#probat
Drug-related				
Property				
Prostitution				
Sex Offenses				
Theft				
Violence				
Weapons				
Other				

Court Information

105. Was there an arrest?

- 1. Yes
- 2. No
- 99. Unknown

106. Criminal charges pursued by prosecutor?

- 1. Yes
- 2. No
- 99. Unknown

107. Court activities: _____

FAMILY COURT INFORMATION, PFA Unit

108. Was the decedent known to Family Court for Protection From Abuse (PFA) involvement?

- 1. Yes
- 2. No
- 99. Unknown

109. In how many PFA cases was the decedent known to Family Court? _____

Family Court Cases:

<u>Date</u>	<u>Decedent was:</u>	<u>PERP was</u>	<u>Result</u>	<u>If Final Order, date of entry</u>
1.	1. Plaintiff 2. Defendant 3. Both 4. Acting on behalf of a minor plaintiff	1. Plaintiff 2. Defendant 3. Both 97. Not involved	1. Dismissed for lack of prosecution 2. Final Order entered 3. Active at time of death 4. Other _____ 99. Unknown	
2.	1. Plaintiff 2. Defendant 3. Both 4. Acting on behalf of a minor plaintiff	1. Plaintiff 2. Defendant 3. Both 97. Not involved	1. Dismissed for lack of prosecution 2. Final Order entered 3. Active at time of death 4. Other _____ 99. Unknown	
3.	1. Plaintiff 2. Defendant 3. Both 4. Acting on behalf of a minor plaintiff	1. Plaintiff 2. Defendant 3. Both 97. Not involved	1. Dismissed for lack of prosecution 2. Final Order entered 3. Active at time of death 4. Other _____ 99. Unknown	
4.	1. Plaintiff 2. Defendant 3. Both 4. Acting on behalf of a minor plaintiff	1. Plaintiff 2. Defendant 3. Both 97. Not involved	1. Dismissed for lack of prosecution 2. Final Order entered 3. Active at time of death 4. Other _____ 99. Unknown	

INTIMATE PARTNER VIOLENCE INFORMATION

Decedent

1. Prior reports to PD about intimate partner violence?

- 1. Yes
- 2. No
- 99. Unknown

4. Both V and P

- 1. Yes
- 2. No
- 99. Unknown

101. In report(s) decedent was:

- 2. Victim
- 3. Perpetrator
- 4. Both V and P

109. DOM team ever involved:

- 1. Yes
- 2. No
- 99. Unknown

102. Other accounts of domestic violence (Fam/frnd/agency)?

- 1. Yes
- 2. No
- 99. Unknown

110. Victim assistance officer(s) ever involved?

- 1. Yes
- 2. No
- 99. Unknown

103. In accounts decedent was:

- 2. Victim
- 3. Perpetrator

Perpetrator

111. Prior reports to PD about intimate partner violence?

- 1. Yes
- 2. No
- 99. Unknown

112. Perpetrator was:

- 2. Victim
- 3. Perpetrator
- 4. Both V&P

113. Other accounts of IPV (Family/friends/agency)?

- 1. Yes
- 2. No
- 99. Unknown

114. Perpetrator was:

- 2. Victim
- 3. Perpetrator
- 4. Both V&P

115. Prior PFA's (Other women)

How many: _____

SUMMATION:

- Selected for Review?
 - Reviewed?
 - Family member known to PIFYRT?
 - Case to bring back?
-

NOTES:

Appendix D – Death Certificate

H105.143 R
TYPE/PRI
PERMANENT
BLACK INK

effective
2006

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF REVENUE
CERTIFICATE OF DEATH

DECEDENT'S PERSONAL DATA

1. Name of Decedent (First, middle, last)							
5. Age (Last birthday) Yrs	6. Under 1 year Months Days		Under 1 day Hours Minutes		7. Date of Birth (Month, day, year)	8. Birthplace (City and state or foreign country)	
	8b. County of Death			8c. City, Boro, Twp. of Death		8d. Facility Name (If not institution, give street address)	
11. Decedent's Usual Occupation (Kind of work done during most of working life; do not state retired) Kind of Work			Kind of Business/Industry			12. Was Decedent ever in the US Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No	13. Decedent's Education Elementary/Secondary/College
16. Decedent's Mailing Address (Street, city/town, state, zip code)					Decedent's Actual Residence		17a. State _____ 17b. County _____
18. Father's Name (First, middle, last)						19. _____	
20a. Informant's Name (Type/print)						20b. _____	

ALIAS USED

DISPOSITION

21a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other - Specify: _____	21b. Date of Disposition (Month, day, year)	21c. _____
22a. Signature of Funeral Service Licensee (or person acting as such)		22b. License Number

PRONOUNCING

Complete Items 23a-c only when certifying physician is not available at time of death to certify cause of death.	23a. To the best of my knowledge, death occurred at the time, date and place stated. (Signature and title)	
Items 24-26 must be completed by person who pronounces death.	24. Time of Death M.	25. Date Pronounced Dead (Month, day, year)

Appendix E – List of Acronyms

List of Acronyms

BHTEN Behavioral Health Training and Education Network

CBH Community Behavioral Health

CDC Centers for Disease Control and Prevention

DBH Department of Behavioral Health?

DHS Department of Human Services

DV Domestic Violence

HIV/AIDS Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome

IPV Intimate Partner Violence

IPV Homicides Intimate Partner Violence Homicides (Homicide as a direct result of IPV)

OMH Office of Mental Health

OSH Office of Supportive Housing

PDPH Philadelphia Department of Public Health

PFA Protection From Abuse

PLA Philadelphia Legal Assistance

PHMC Philadelphia Health Management Corporation

PWDRT Philadelphia Women's Death Review Team

SWHSTF Sex Workers Health and Safety Task Force

WAA Women Against Abuse

WAALC Women Against Abuse Legal Center

WIT Women in Transition, Inc.

WLP Women's Law Project

WOAR Women Organized Against Rape

Other Abbreviation

"The Team" – Philadelphia Women's Death Review Team (PWDRT)

DOM Team – Domestic Case Team at the Police Department

**Appendix F – Profile of Deaths of Philadelphia Women (ages 15-60),
1997-2006**

Deaths Among Philadelphia Women (Ages 15-60), 1997-2006

	1997		1998		1999		2000		2001		2002		2003		2004		2005		2006	
Manner of Death	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Natural	1192	83.3	1135	84.7	1243	87.1	1207	81.8	1249	84.3	1226	83.6	1224	83.5	1201	82.9	1115	81.9	1122	84.6
Accident	142	9.9	121	9.0	113	7.9	154	10.4	151	10.2	128	8.7	116	7.9	138	9.5	140	10.3	122	9.2
Homicide	46	3.2	48	3.6	35	2.5	35	2.4	32	2.2	31	2.1	42	2.9	29	2.0	23	1.7	34	2.6
Suicide	30	2.1	29	2.2	21	1.5	29	2.0	29	2.0	27	1.8	31	2.1	21	1.4	28	2.1	18	1.4
Undetermined	21	1.5	4	0.3	15	1.1	15	1.0	10	0.7	17	1.2	14	1.0	22	1.5	20	1.5	17	1.3
Pending	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	8	0.6	9	0.7	0	0.0
Not Provided	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	30	2.1	26	1.9	14	1.1
Race																				
White	521	36.4	515	38.4	554	38.8	584	39.6	570	38.5	563	38.4	583	39.8	554	38.2	516	37.9	514	38.7
Black	820	57.3	748	55.8	834	58.4	850	57.6	868	58.6	881	60.1	851	58.1	860	59.4	820	60.2	790	59.5
Asian	19	1.3	21	1.6	21	1.5	3	0.2	9	0.6	2	0.1	1	0.1	29	2.0	23	1.7	22	1.7
Other/Unknown	71	5.0	56	4.2	18	1.3	38	2.6	33	2.2	21	1.4	9	0.6	6	0.4	2	0.1	1	0.1
Ethnicity							0.0		0.0		0.0		0.0		0.0		0.0		0.0	
Hispanic	65	4.5	65	4.9	56	3.9	86	5.8	78	5.3	82	5.6	93	6.3	81	5.6	74	5.4	60	4.5
Non-Hispanic	1366	95.5	1275	95.1	1260	88.3	1367	92.7	1401	94.6	1385	94.4	1359	92.8	1365	94.2	1286	94.5	1261	95.0
Unknown	0	0.0	0	0.0	111	7.8	22	1.5	2	0.1	0	0.0	13	0.9	3	0.2	1	0.1	6	0.5
Age																				
15-19	31	2.2	19	1.4	14	1.0	20	1.4	18	1.2	17	1.2	21	1.4	22	1.5	23	1.7	16	1.2
20-24	45	3.1	34	2.5	32	2.2	29	2.0	34	2.3	37	2.5	26	1.8	24	1.7	38	2.8	25	1.9
25-29	54	3.8	42	3.1	45	3.2	56	3.8	39	2.6	45	3.1	43	2.9	39	2.7	38	2.8	34	2.6
30-34	104	7.3	76	5.7	84	5.9	72	4.9	59	4.0	60	4.1	71	4.8	56	3.9	56	4.1	44	3.3
35-39	118	8.2	126	9.4	139	9.7	136	9.2	132	8.9	117	8.0	117	8.0	104	7.2	86	6.3	79	6.0
40-44	188	13.1	185	13.8	168	11.8	179	12.1	195	13.2	212	14.5	185	12.6	188	13.0	169	12.4	143	10.8
45-49	242	16.9	219	16.3	242	17.0	243	16.5	234	15.8	248	16.9	243	16.6	279	19.3	244	17.9	248	18.7
50-54	300	21.0	281	21.0	278	19.5	318	21.6	325	21.9	299	20.4	313	21.4	289	19.9	275	20.2	308	23.2
55-60	349	24.4	358	26.7	425	29.8	422	28.6	445	30.0	432	29.4	446	30.4	448	30.9	432	31.7	430	32.4
Total Deaths	1431		1340		1427		1475		1481		1467		1465		1449		1361		1327	

Source: Philadelphia Department of Public Health Philadelphia Vital Statistics Electronic File

Deaths Rates Among Philadelphia Women (Ages 15-60), 1997-2006, By Manner of Death

Manner of Death	Rate per 100,000 Women									
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Natural	255.2	251.6	271.07	244.4	254.4	250.7	251.6	249.0	233.6	235.0
Accident	30.4	26.8	24.8	31.02	32.1	21.7	21	28.6	29.3	25.6
Homicide	9.9	10.1	7.8	7.1	7.1	5.9	8.02	6.0	4.8	7.1
Suicide	6.4	6.3	4.4	5.9	6.1	5.8	6.4	4.4	5.9	3.8
Undetermined	4.5	1.1	3	2.8	2	3.5	2.9	4.6	4.2	3.6
Pending	0	0	0	0	0	0	0	1.7	1.9	0.0
Not Provided	0	0	0	0	0	0	0	6.2	5.4	2.9
All Deaths	306.3	288.9	310.7	298.6	301	287.5	289.8	300.4	285.1	277.9

Source: Philadelphia Department of Public Health Philadelphia Vital Statistics Electronic File

Table 1: Deaths of Philadelphia Women (Ages 15-60) by Manner of Death and Reason for Review, 2004 and 2006

Manner of Death and Reason for Review	Number of Deaths²¹	Deaths Selected for Review*
Natural		194
<i>AIDS/HIV</i>	3,438	62
<i>Long-term D/A Abuse</i>		66
<i>Questionable Circumstances</i>		24
<i>Pregnancy-Associated</i>		7
<i>Other</i>		35
Accidental Injury		167
<i>Long-term D/A Abuse</i>	400	23
<i>Adverse Effects of Drugs</i>		118
<i>Questionable Circumstances</i>		15
<i>Other</i>		11
Homicide	86	83
Suicide		40
<i>Suicide</i>	68	39
<i>Pregnancy-Associated</i>		1
Undetermined Cause		45
<i>Long-term D/A Abuse</i>	58	3
<i>Adverse Effects of Drugs</i>		13
<i>Questionable Circumstances</i>		28
<i>Pregnancy-Associated</i>		1
TOTAL	4050	529

Source: Philadelphia Electronic Vital Statistic 2004 - 2006, Philadelphia Department of Public Health and PWDRT data

*Note that reasons for review may sum to a total greater than the number of cases reviewed as a case might have been selected for multiple reasons. Note total does not include “pending” and cases for which manner of death was not provided so total may be less than number of total deceased. Two women were selected for review because the Clinical Screening Committee and the Review Team determined that they were residents of Philadelphia, although this was not recorded on their death certificates. Residency was discussed at the Review meeting, and if a woman lived unofficially with a relative or partner in Philadelphia (not on a lease or public record, but spent most or all of her time at the residence), she was included in review as an official resident.

Table 2: PWDRT Reviewed Deaths of Philadelphia Women (Ages 15-60) by Manner of Death, 1997-2006

Manner of Death (N=3159)							
	Natural	Unintentional Injury	Suicide	Homicide	Undetermined	Unknown*	TOTAL by year
Year							
1997	211	121	30	47	21	0	430
1998	148	81	29	48	4	3	313
1999	218	77	21	35	16	0	367
2000	208	124	29	35	13	7	416
2001	191	123	30	35	10	4	393
2002	211	101	28	31	21	1	393
2003	156	76	29	44	13	0	318
2004	21	22	7	28	16	0	94
2005	33	54	16	19	14	0	136
2006	140	91	17	36	15	0	299
TOTAL	1537	870	236	358	143	15	3159

Source: Philadelphia Department of Public Health and PWDRT data

Table 3: Number and Percent of Philadelphia Women (Ages 15-60) with a History of Domestic Violence or IPV, by Manner of Death, 1997-2006

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	TOTAL
	n										
	(%)										
Natural	5 26%	2 16%	2 11%	5 17%	27 33%	26 42%	17 40%	1 6%	12 31%	40 44%	137 33%
Accident	1 5%	1 8%	2 11%	10 35%	31 38%	19 31%	11 26%	5 31%	15 38%	23 26%	118 29%
Suicide	1 5%	0 0%	0 0%	1 3%	6 7%	4 7%	1 2%	1 6%	2 5%	4 4%	20 5%
Homicide	10 53%	9 75%	15 79%	10 35%	14 17%	9 15%	11 26%	6 38%	5 13%	21 23%	110 27%
Undetermined	2 11%	0 0%	0 0%	3 10%	3 4%	4 6%	3 7%	3 19%	5 13%	2 3%	25 6%
TOTAL n	19	12	19	29	81	62	43	16	39	89	410

Source: Philadelphia Department of Public Health and PWDRT data

Table 4: Women with a History of Domestic or Intimate Partner Violence

History Domestic Violence or IPV	1997 – 2006 (n = 410)
Age (mean average)	38
Black	(58%, n=239)
Non-Hispanic	(90%, n=369)
High School graduate	(53%, n=218)
Homeless or known to OESS	(9%, n=37)
Unemployed	(75%, n=306)
Personal and family histories included:	
Substance Abuse	(44%, n=182)
Criminal History	(35%, n=143)
Diagnosis or Mental Health Treatment	(30%, n=124)
History of sexual abuse as a child	(7%, n=29)
History of abuse or neglect as a child Perpetrator of child abuse or neglect	(10%, n=39)
Family history of child abuse or neglect, or child sexual abuse	(13%, n=53)
Family history of a perpetrator of child abuse or neglect	(6%, n=26)
	(2%, n=9)

Table 5: Demographic Profile of Deaths to Philadelphia Women (Ages 15-60) by Manner of Death, 2004 – 2006

Age	All Deaths*		Natural		Accident		Homicide		Suicide		Undetermined		Pending		Not Provided	
		%		%		%		%		%		%		%		%
15-19	61	1.47	31	0.90	10	2.5	11	12.79	5	7.35	2	3.45	1	5.88	1	1.43
20-24	87	2.10	31	0.90	28	7	17	19.77	6	8.82	2	3.45	0	0.00	3	4.29
25-29	111	2.68	58	1.69	29	7.25	13	15.12	5	7.35	2	3.45	1	5.88	3	4.29
30-34	156	3.77	100	2.91	33	8.25	7	8.14	9	13.24	4	6.90	1	5.88	2	2.86
35-39	269	6.50	183	5.32	58	14.5	9	10.47	6	8.82	5	8.62	3	17.65	5	7.14
40-44	500	12.09	398	11.58	74	18.5	6	6.98	8	11.76	6	10.34	1	5.88	7	10.00
45-49	771	18.64	645	18.76	74	18.5	11	12.79	9	13.24	15	25.86	4	23.53	13	18.57
50-54	872	21.08	783	22.77	41	10.25	8	9.30	11	16.18	11	18.97	3	17.65	15	21.43
55-59	1085	26.23	1004	29.20	43	10.75	3	3.49	6	8.82	8	13.79	3	17.65	18	25.71
60	225	5.44	205	5.96	10	2.5	1	1.16	3	4.41	3	5.17	0	0.00	3	4.29
Race																
Black	2,470	59.71	2149	62.51	180	45	69	80.23	14	20.59	23	39.66	10	58.82	25	35.71
White	1584	38.29	1223	35.57	213	53.25	16	18.60	51	75.00	34	58.62	7	41.18	40	57.14
Asian	74	1.79	62	1.80	5	1.25	1	1.16	3	4.41	1	1.72	0	0.00	2	2.86
Other/Unknown	6	0.15	4	0.12	2	0.5	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Ethnicity																
Hispanic	212	5.12	169	4.92	25	6.25	4	4.65	5	7.35	4	6.90	1	5.88	4	5.71
Non-Hispanic	3912	94.56	3263	94.91	372	93	82	95.35	62	91.18	54	93.10	16	94.12	63	90.00
Unknown/No data	10	0.24	6	0.17	0	0	0	0.00	1	1.47	0	0.00	0	0	3	4.29
Total	4137		3438		400		86		68		58		17		70	

Source: Philadelphia Electronic City File 2004 and 2005, Philadelphia Department of Public Health

*In 2004, the manner of death was unknown in 30 cases and pending in eight cases at the time of the city file release. In 2005, an additional 26 cases had no manner of death listed, and nine were pending at the time of the city file release. In 2006, 14 cases had no manner of death listed, at the time of the city file provided its preliminary 2006 report. Percentages may not total 100% due to rounding. In 2006, an additional 14 cases had no manner of death listed

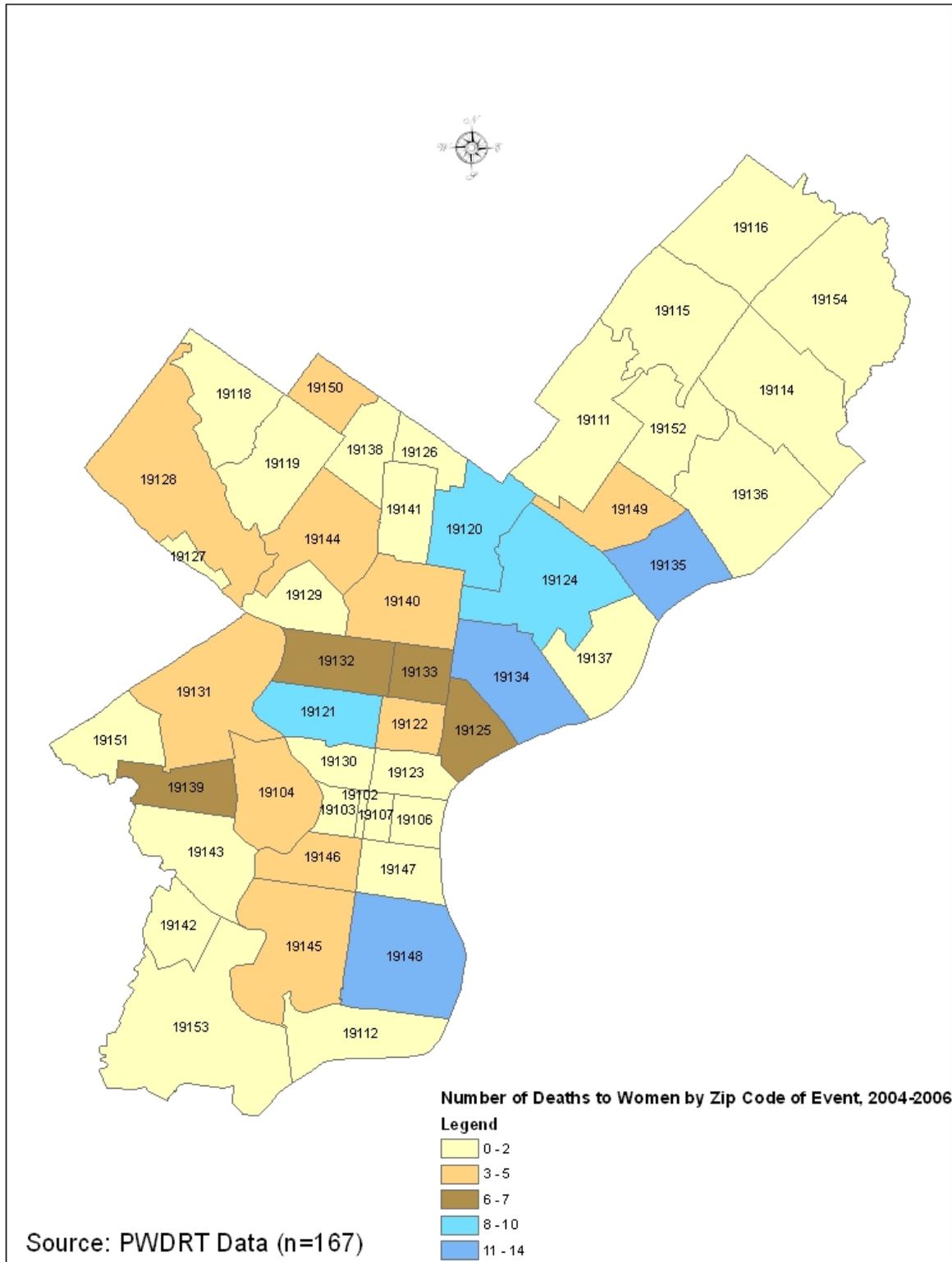
Appendix G – Agencies Addressing Violence-Related Mortality in Women

Philadelphia Agencies Addressing Violence-Related Mortality in Women

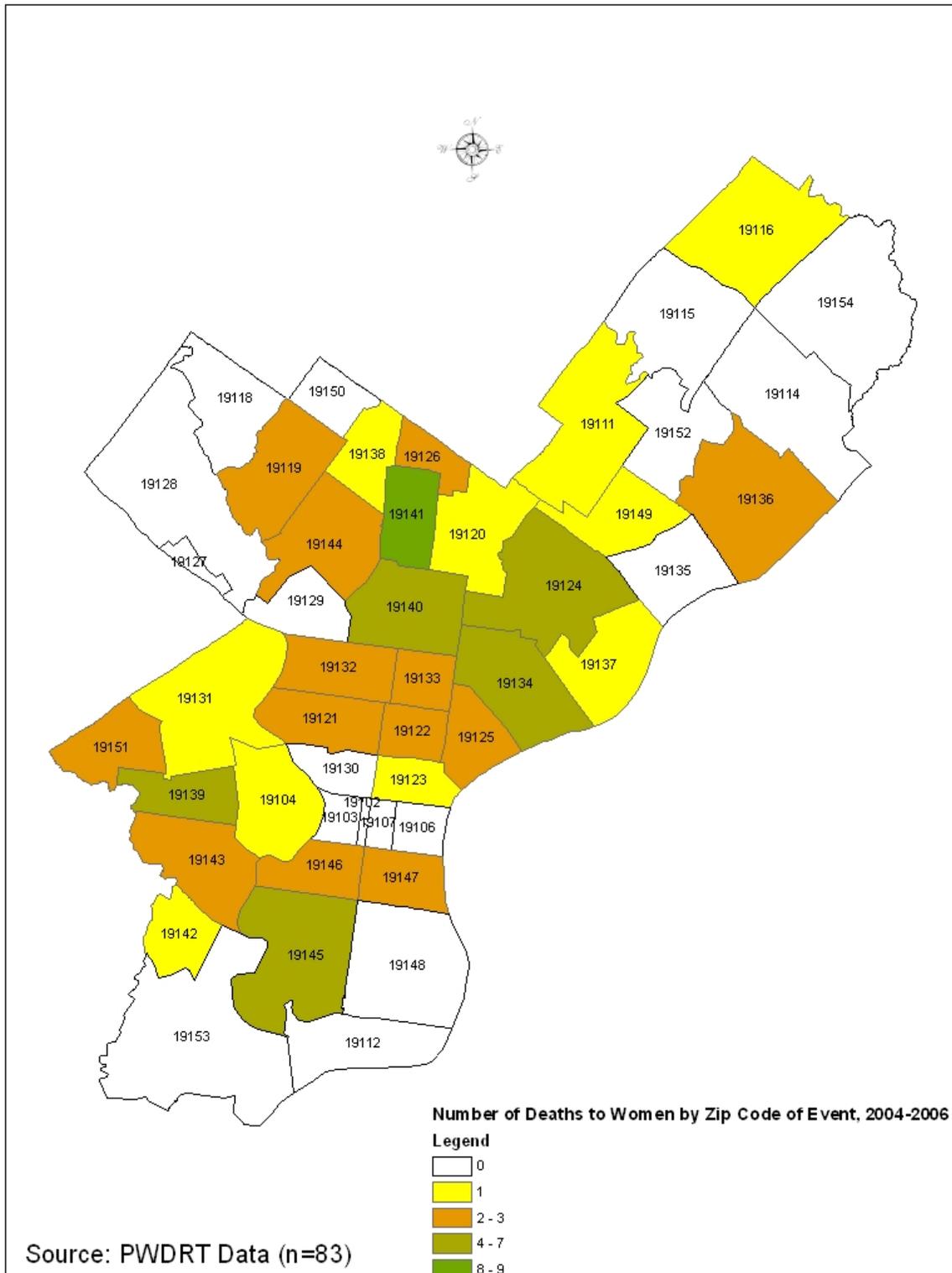
Agencies	Zip codes	Services
<p>Women in Transition- WIT</p> <p>215-751-1111- Contact</p> <p>www.womenintransitioninc.org</p>	Citywide	Provides empowerment counseling, referrals and advocacy to women in Philadelphia who are endangered by domestic violence and/or substance abuse. WIT also provides trainings, workshops, and systems advocacy to eliminate violence against women and children
<p>Women Against Abuse, Inc- WAA</p> <p>215-386-4545- Shelter 1866-723-3014- Hotline</p> <p>www.womenagainstabuse.org</p>	Citywide	WAA provides quality and compassionate services to women and their children victimized by domestic violence in a manner that fosters self-respect and independence from an abuser.
<p>Women's Law Project- WLP</p> <p>215-928-9801- Contact</p> <p>www.womenslawproject.org</p>	Citywide	WLA give basic self-help information about procedures and laws regarding a wide range of subjects of concern to Pennsylvania women. Family-related topics include domestic violence, child custody, child and spousal support, separation and divorce, and the legal rights of lesbian and gay parents. Work-related topics include family and medical leave, sexual harassment, and employment discrimination.
<p>Women Organized Against Rape- WOAR</p> <p>215-985 3333- Hotline</p> <p>www.woar.org</p>	Citywide	WOAR's provides a 24-hour hotline, free individual and group counseling to children and adults who have experienced sexual abuse/sexual assault, counseling in Spanish, hospital and court accompaniment, Latino outreach services, and Asian outreach services.
<p>Philadelphia Legal Assistance-PLA</p> <p>215-981-3800- Hotline</p> <p>www.philalegal.org</p>	Citywide	PLA provides free civil legal services to Philadelphia's low-income community. PLA assists with obtaining protection orders for battered women, other adults and children who are being abused by family or household members.
<p>Lutheran Settlement House- LSH</p> <p>215-426-8610</p> <p>www.lutheransettlement.org</p>	Citywide	LSH mission is to empower individuals, families, and communities to achieve and maintain self-sufficiency through an integrated program of social, educational, and advocacy services."

Appendix H – Maps

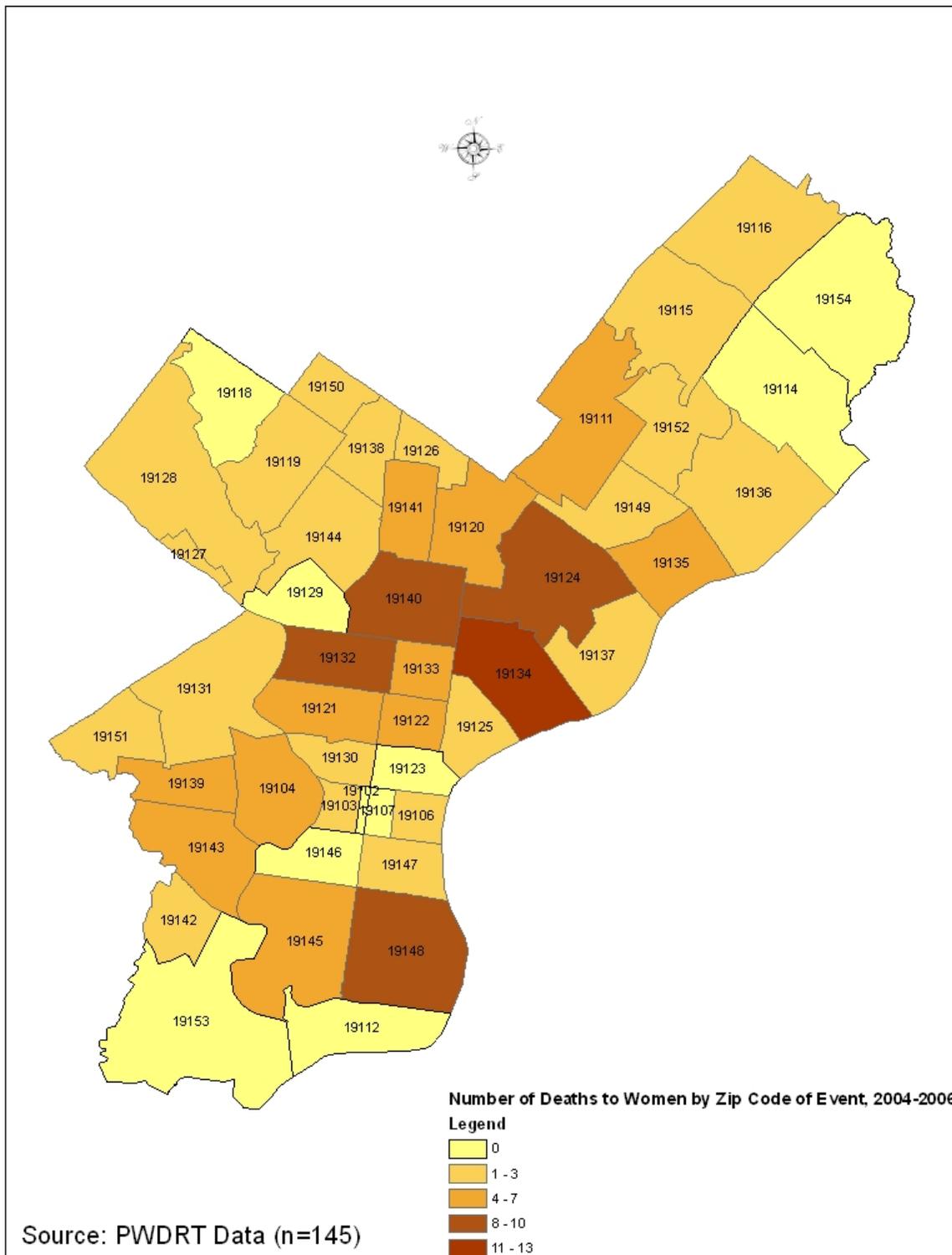
MAP 3. Accident Deaths Among Philadelphia Women (Age 15-60), Reviewed by PWDRT by Zip Codes 2004-2006



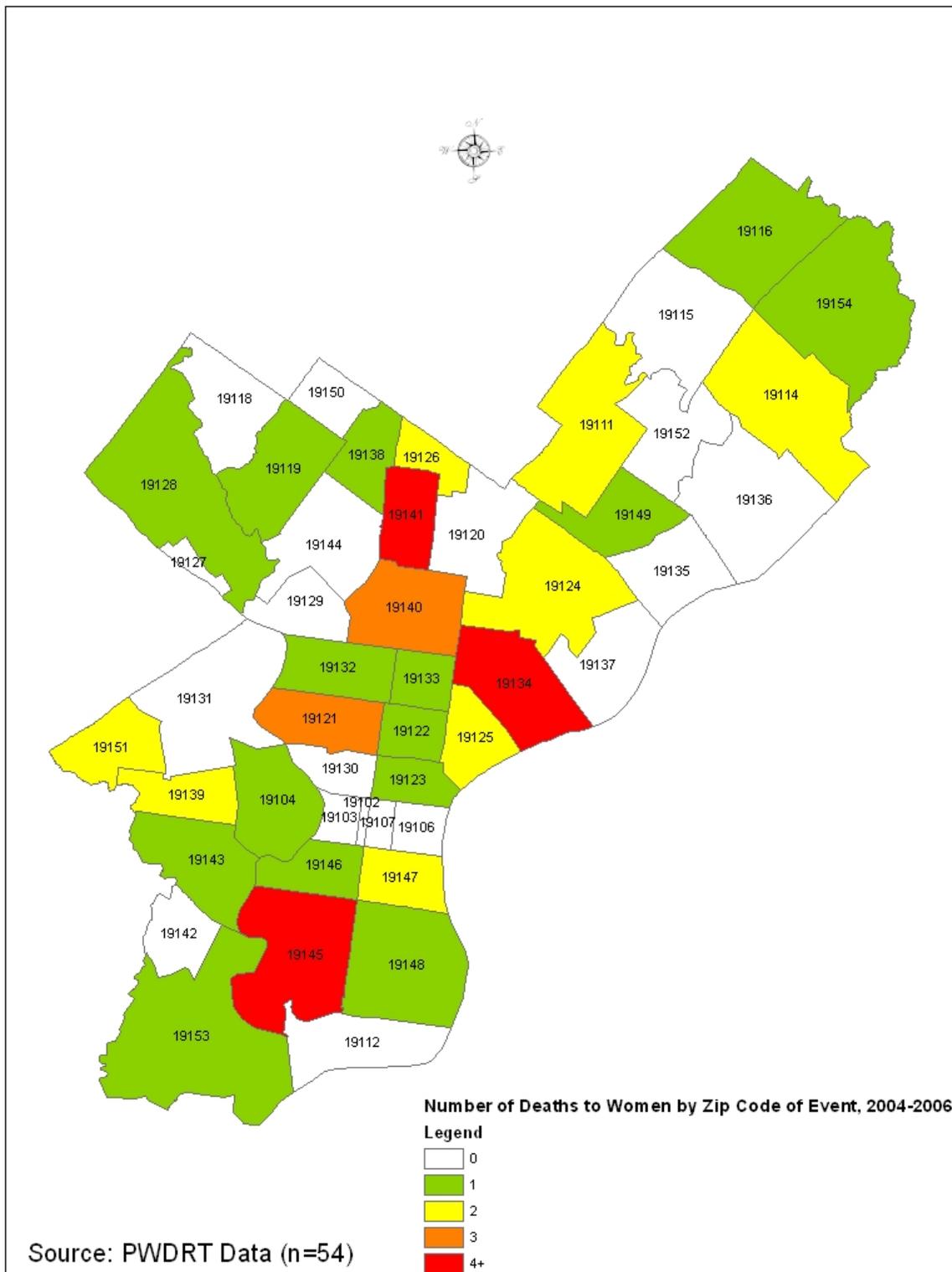
**MAP 4. Homicide Deaths Among Philadelphia Women (Age 15-60),
Reviewed by PWDRT by Zip Codes 2004-2006**



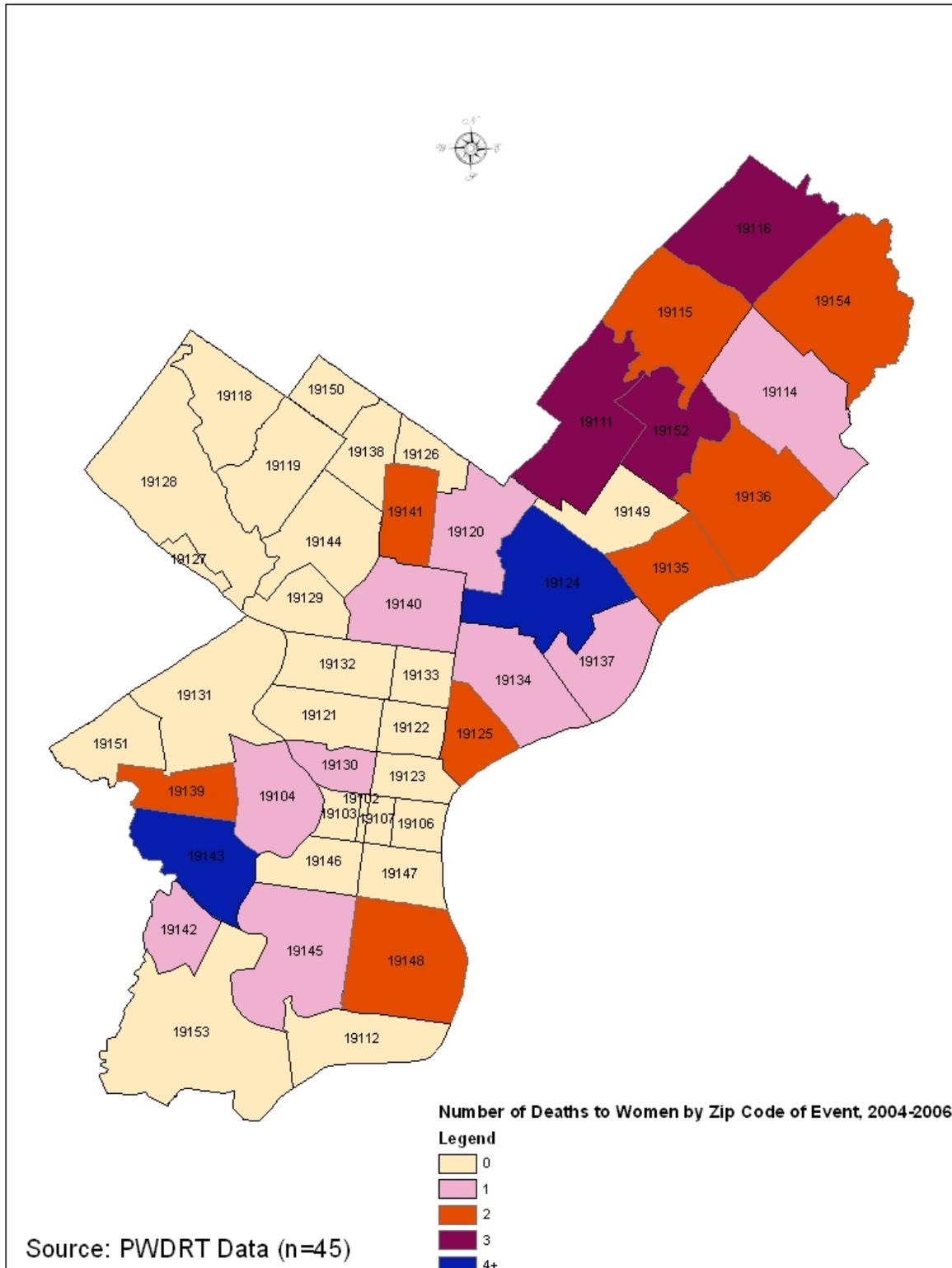
MAP 5. Deaths Among Philadelphia Women (Age 15-60), with a History of Domestic & Intimate partner Violence Reviewed by PWDRT by Zip Codes 2004-2006



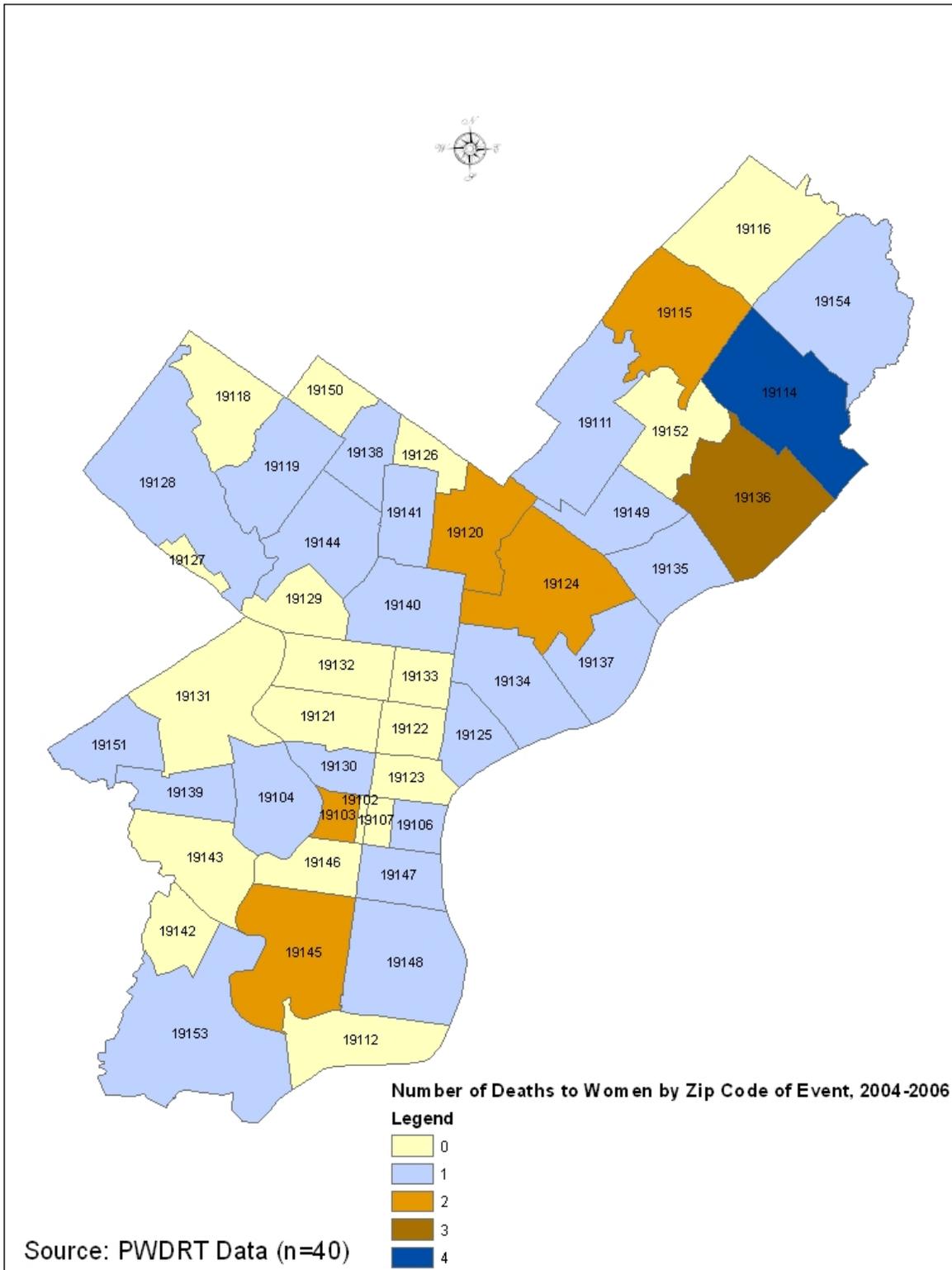
MAP 6. Locations of Firearm Deaths Among Philadelphia Women (Age 15-60), Reviewed by PWDRT by Zip Codes 2004-2006



MAP 7. Undetermined Deaths Among Philadelphia Women (Age 15-60), Reviewed by PWDRT by Zip Codes 2004-2006



MAP 8. Suicide Deaths Among Philadelphia Women (Age 15-60), Reviewed by PWDRT by Zip Codes 2004-2006



MAP 9. Deaths from Adverse Effect of Drugs Among Philadelphia Women (Age 15-60), Reviewed by PWDRT by Zip Codes 2004-2006

