

NATIONAL VIOLENT DEATH REPORTING SYSTEM



Stories from the Frontlines of Violent Death Surveillance



NVDRS: STORIES FROM THE FRONTLINES OF VIOLENT DEATH SURVEILLANCE

About the Safe States Alliance

Established in 1993, the Safe States Alliance is a national non-profit organization and professional association whose mission is to strengthen the practice of injury and violence prevention. Safe States is the only national non-profit organization and professional association that represents the diverse and ever-expanding group of professionals who comprise the field of injury and violence prevention. Safe States Alliance engages in a variety of activities to advance the organization's mission, including:

- Increasing awareness of injury and violence throughout the lifespan as a public health problem;
- Enhancing the capacity of public health agencies and their partners to ensure effective injury and violence prevention programs by disseminating best practices, setting standards for surveillance, conducting program assessments, and facilitating peer-to-peer technical assistance;
- Providing educational opportunities, training, and professional development for those within the injury and violence prevention field;
- Collaborating with other national organizations and federal agencies to achieve shared goals;
- Advocating for public health policies designed to advance injury and violence prevention;
- Convening leaders and serving as the voice of injury and violence prevention programs within state health departments; and
- Representing the diverse professionals making up the injury and violence prevention field.

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NVDRS: STORIES FROM THE FRONTLINES OF VIOLENT DEATH SURVEILLANCE

FOREWORD

We are pleased to present, NVDRS: Stories from the Frontlines of Violent Death Surveillance, a document designed to communicate the unique capacity of the National Violent Death Reporting System (NVDRS) and the benefits states gain from participating in this nationwide, state-based surveillance system.

The NVDRS links data from vital statistics, medical examiners and coroners, law enforcement, crime laboratories, and other sources to provide – for the first time – a more complete understanding of violent deaths in the U.S., states and local communities. It was established in 2002, is funded by CDC and currently operates in 18 states. The goal is to expand NVDRS participation to all U.S. states and territories.

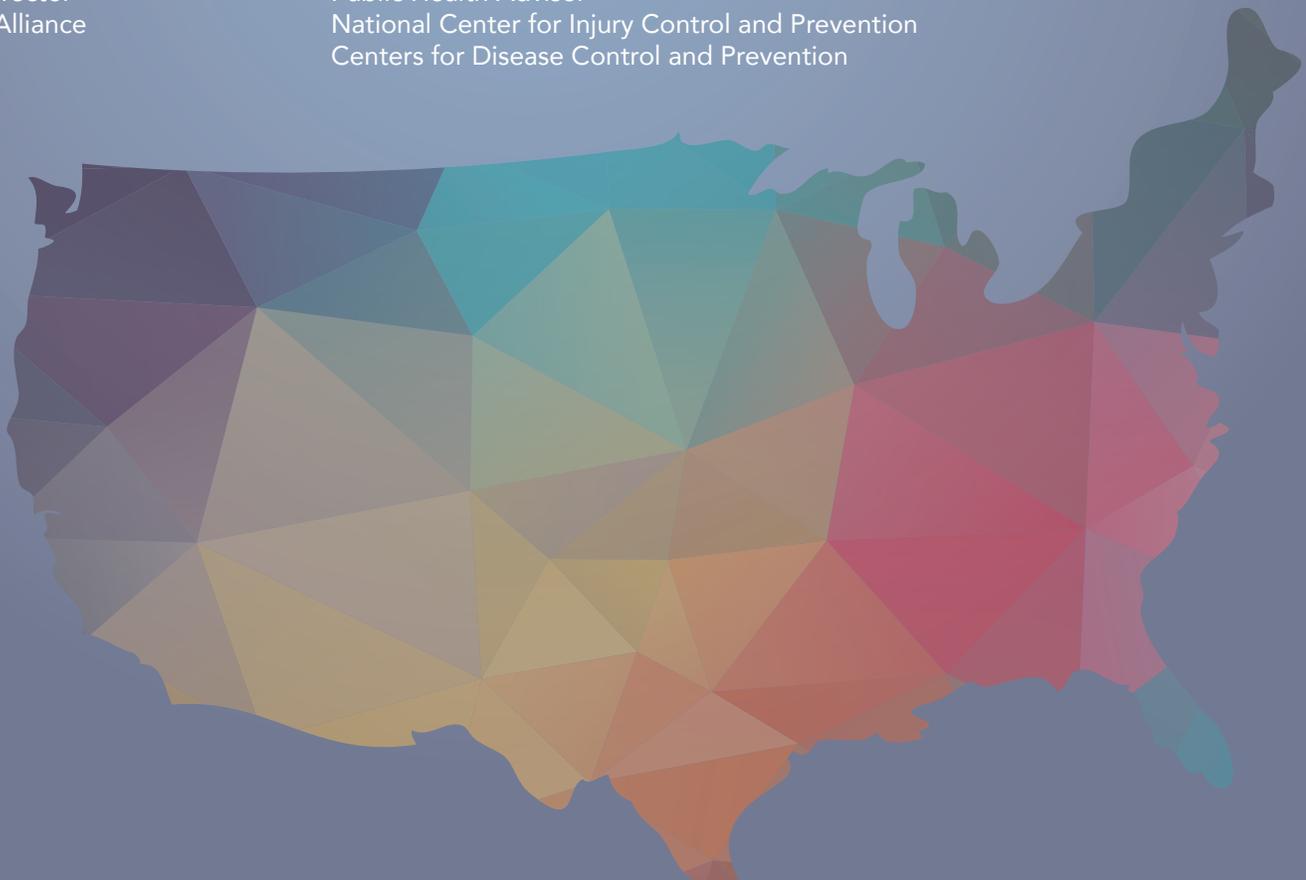
The stories in this document highlight the experience of several NVDRS states by first telling the story of a typical violent death in the state. Each story is told using the kind of data typically gleaned from NVDRS sources – information about victims and suspects, their relationships, important circumstances contributing to the death, and weapons used. To protect confidentiality, the stories reflect typical information, not real deaths.

The document also presents recent rates and trends for specific types of violent deaths – valuable data generated by state violent death reporting systems not feasibly collected, linked and analyzed prior to the NVDRS. These data expand our understanding of factors contributing to violent deaths, from homicide-suicides to suicides related to domestic violence and elder abuse. Also included are exciting examples of how states have translated NVDRS data into actions targeting and informing violence prevention efforts at state and local levels.

We hope you find this an engaging, useful tool for demonstrating the unique capacity of the NVDRS, building support for this surveillance system and helping expand state participation. As this document illustrates, linking data about violence can save lives.

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NVDRS: STORIES FROM THE FRONTLINES OF VIOLENT DEATH SURVEILLANCE

THE NATIONAL VIOLENT DEATH REPORTING SYSTEM (NVDRS)

Creating a more complete picture of violent deaths

In 2010, over 16,250 people were victims of homicide and over 38,360 took their own life, according to the CDC. Valuable information about these and other violent deaths is collected by many sources – law enforcement agents, coroners, medical examiners, crime lab investigators, and state vital records offices. But these data are rarely combined in a systematic way to provide a complete picture of violent incidents – **a picture with details about victims and suspects, their relationships, important circumstances contributing to a death, and weapons used.**

The National Violent Death Reporting System (NVDRS) is a nationwide, state-based surveillance system established in 2002 and funded by CDC to collect data on violent deaths from participating states. The CDC currently funds 18 states, who have each established a state violent death reporting system and voluntarily report state data to CDC.

Linking data from multiple sources

The NVDRS collects and links data from four major sources about the same violent death incident:

- Death certificates
- Coroner/medical examiner reports
- Law enforcement reports
- Crime laboratories

Some states may incorporate additional data sources, including Child Fatality Reviews or Domestic Violence Fatality Reviews. After all identifying information is removed, these data are linked in an anonymous state database and submitted to the NVDRS. The names of individual victims and suspects are not released, and laws protecting other types of health department records, such as communicable disease records, also apply to NVDRS files.

The power of an *incident*-based system

While some systems – such as vital statistics – count deaths, the NVDRS collects data on the *entire violent incident*. A single incident can have one or more victims and/or suspects. The NVDRS can identify all victims in a multi-homicide, or link victims and a suspect in a homicide-suicide.

Linking data into one database places a death into context and provides information not previously possible, such as:

- the relationship between the victim and perpetrator, including if they knew each other;
- information about the perpetrator, including criminal history;
- circumstances such as a history of depression or other mental health problems, chronic illness, alcohol or drug use, recent problems with a job, finances or relationships, gang activity, or the recent death of a family member; and
- circumstances unique to intimate partner violence, including prior incidents of abuse.

Translating data into action

The NVDRS provides the nation, states and communities with a clearer understanding of violent deaths and their circumstances by:

- describing the magnitude of and trends for specific types of violence,
- identifying risk factors associated with violence at state and local levels, and
- targeting and guiding state and local violence prevention programs, policies and practices.

CURRENT NVDRS STATES

Alaska
Colorado
Georgia
Kentucky
Maryland
Massachusetts
Michigan
New Jersey
New Mexico
North Carolina
Ohio
Oklahoma
Oregon
Rhode Island
South Carolina
Utah
Virginia
Wisconsin

WHAT IS A VIOLENT DEATH?

According to the CDC: A violent death is a death that results from the intentional use of physical force or power, threatened or actual, against oneself, another person, or a group or community.



NVDRS: STORIES FROM THE FRONTLINES OF VIOLENT DEATH SURVEILLANCE

TYPICAL DATA FROM NVDRS SOURCES

DEATH CERTIFICATE

- Age
- Gender
- Residence
- Marital status
- Profession
- Employment status
- Veteran status
- Cause of death
- Manner of death
- Time of death
- Pregnancy status

MEDICAL EXAMINER/ CORONER

- Brief narrative of incident
- Demographics
- Wound location
- Weapon information, patterns on victim
- Cause of death
- Manner of death
- Current disease/ health condition
- Current/recent medical treatment
- Current medication
- Relationships among involved persons (if available)
- Circumstances relevant to death

TOXICOLOGY

- Presence or absence of alcohol or drugs in victim(s)

LAW ENFORCEMENT

- Narrative on the circumstances of the death
- Wound locations
- Weapon information
- Relationships among victim, perpetrator, others involved
- Information on suspect(s)
- Potential evidence to substantiate/support conclusion about violent death type (suicide, homicide)
- Presence/absence of suicide note
- Interviews with any witnesses, family members, others
- Critical stressors in victim's life

CHILD FATALITY REVIEW

Information on victim's:

- Household
- Caregivers
- Supervision
- Previous contacts with child protective services
- Relationship with perpetrator

DOMESTIC VIOLENCE FATALITY REVIEW

Information on current/ former girlfriend, boyfriend, date, spouse

- Length of relationship
- Breakup/breakup in progress
- Court/prosecutor & restraining order records
- Domestic-violence related services (safety planning, shelter, lethality assessment)
- Perpetrator criminal history, charge/conviction
- # of children exposed to homicide

CRIME LAB

- Firearms involved
- Type, make & model
 - Caliber or gauge
 - Serial number
 - Importer's name & address



DATA ELEMENTS OVERLAP

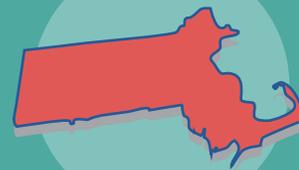
Same information may come from multiple sources

MASSACHUSETTS Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Massachusetts Department of Public Health,
Injury Surveillance Program

Collecting data since 2003



DEATH CERTIFICATE

- Homicide victim: 43-year-old white female
- Suicide victim: 52-year-old white male



MEDICAL EXAMINER

- Female died from 4 gunshot wounds to torso
- Male died from 1 gunshot to head



LAW ENFORCEMENT

- Co-worker stated victim had broken up with suspect 10 days ago
- No prior reports of domestic violence

A HOMICIDE-SUICIDE IN MASSACHUSETTS

The example below tells the story of a *typical* homicide-suicide in Massachusetts, but to ensure confidentiality, it is not the story of an actual death. The example was created to illustrate the violent death data typically collected and linked in the Massachusetts Violent Death Reporting System (MAVDRS).

DEATH CERTIFICATE

The victim was a 43-year-old white female. She was injured and died in her residence from gunshot wounds. The manner of death was homicide. She was an office secretary. Another victim was a 52-year-old white male. He died at the scene from a gunshot wound to the head. The manner of death was suicide. He was a laborer working in construction.



MEDICAL EXAMINER

Police responded to the victim's residence. The victim, a 43-year-old white female, died from 4 gunshot wounds to her torso. A second victim, a 52-year-old white male, was also at the scene. He died from a self-inflicted gunshot wound to the head. The male is suspected of killing the female, and then killing himself. The victims were intimate partners.



TOXICOLOGY

Both the victim and the boyfriend had negative toxicology results.



LAW ENFORCEMENT

When the victim, a 43-year-old white female, did not show up for work, the victim's co-workers called police to assist in a well-being check. Police responded to the victim's residence and found her on the floor of the living room with gunshot wounds to her torso. Upon further investigation, police discovered the body of a 52-year-old white male in the rear of the home with a gunshot wound to his head. A co-worker on the scene stated that the deceased male was the victim's estranged boyfriend. The co-worker stated the victim had broken up with the boyfriend 10 days prior after a relationship of many years.



The victim and the boyfriend had one minor child, a 4-year-old son, between them. The child was not at home at the time of the incident. The child was with his grandmother, the victim's mother, who lives nearby. The victim's mother told law enforcement that the victim had complained to her that the boyfriend would get very angry whenever the victim talked about breaking up.

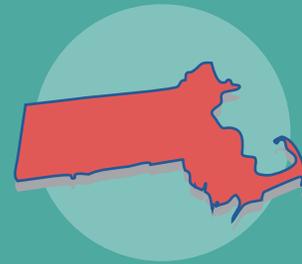
According to police reports, there were no prior incidents of domestic violence reported. Family and neighbors also were unaware of any domestic disturbance between the victim and the boyfriend.

MASSACHUSETTS Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Massachusetts Department of Public Health,
Injury Surveillance Program

Collecting data since 2003



THE BIG PICTURE

Homicide-suicide incidents are rare but violent events with long-lasting effects on families and communities. From 2003-2007 in Massachusetts, there were 41 homicide-suicide incidents in the state that resulted in 49 homicides and 41 suicides, for a total of 90 deaths, per Massachusetts Violent Death Reporting System (MAVDRS) data.

Among the 41 homicide-suicide incidents (in which the fatal injuries were inflicted less than 24 hours apart) during 2003-2007, most were:

- intimate partner violence-related,
- perpetrated by white males,
- involved the use of a firearm,

- did not involve an intoxicated perpetrator,
- had homicide victims who were female and older than all other homicide victims on average, and
- had perpetrators who were known to the homicide victim.

41%
homicide-suicide incidents resulted in **49** homicides & **41** suicides (90 deaths)

TRANSLATING DATA INTO ACTION

Capturing new information

Before the MAVDRS, there was no official way to capture information on homicide-suicide incidents because existing surveillance systems were *person-based*.

- **The MAVDRS is incident-based, which enables identification of multiple deaths from the same incident or between victims and suspects,** and provides a better understanding of the violent deaths.
- Without the MAVDRS, important differences between homicide-suicides and separate, unrelated homicides or suicides could be missed.

Sharing new information

New information about violent deaths is available through the MAVDRS, and the Injury Surveillance Program has disseminated these findings through 7 annual data reports, 4 special bulletins and many responses to data requests. For example, the program:

- identified and disseminated new **findings about an increase in suicides among middle aged white males,**
- identified and disseminated new findings about an increase in multiple-victim incidents in general, and particularly among homicide-suicide incidents,
- is **tracking the emerging issue of suicide by hydrogen sulfide,** which results from mixing household chemicals – chemicals that can produce fumes dangerous to first responders and other people living in the building where an incident occurs;
- **analyzed train-related death data** for the state suicide prevention program;

- **analyzed youth-related violent death data** for the governor's Safe and Successful Youth Program; and
- regularly responds to a variety of **data requests from counties, cities and towns.**

Improving data quality

Because it **double checks data from each source and corrects coding mistakes,** the MAVDRS has improved the quality of data from Vital Records, medical examiners and law enforcement.

Improved collaboration

Other benefits of implementing the MAVDRS are **improved relationships and data sharing among public health, medical examiners and law enforcement agencies.**

Improved collaboration with the Boston Police Department has increased the amount of information on circumstances and suspects that the agency shares with the Injury Surveillance Program.

MAVDRS identifies multiple deaths from the same incident, connects victims & suspects

MAVDRS improved data sharing between public health & Boston Police Department



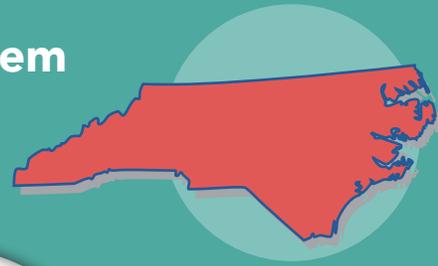
MAVDRS can track emerging issues, e.g. suicide by hydrogen sulfide (household chemicals)

NORTH CAROLINA Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the North Carolina Division of Public Health,
Injury & Violence Prevention Branch

Collecting data since 2004



AN ELDER ABUSE SUICIDE IN NORTH CAROLINA

The example below tells the story of a *typical* elder maltreatment-related suicide in North Carolina, but to ensure confidentiality, it is not the story of an actual death. The example was created to illustrate the violent death data typically collected and linked in the North Carolina Violent Death Reporting System (NC-VDRS).

DEATH CERTIFICATE

The victim was a 62 year old male who died from an intentional overdose of methadone.



MEDICAL EXAMINER/ CORONER

The victim was a 62 year old male who was found unresponsive in his residence by a family member who checked on him every morning. EMS was called and the victim was pronounced dead on the scene. The victim had many health problems which resulted in significant pain. He was prescribed methadone to control the pain. According to his friends, the victim felt his condition was worsening and didn't feel that he would get any better. The victim also had been diagnosed with bipolar disorder and was receiving treatment. The victim was described as depressed in the weeks leading up to his death due to his health condition and limited finances. There was no information on whether the victim had ever attempted or threatened suicide in the past and he did not leave a note. It was determined that the victim died from an intentional overdose of methadone.



LAW ENFORCEMENT

The victim was a 62 year old male who was found unresponsive in his residence after a family member requested authorities do a welfare check on the victim. The victim was found lying unresponsive inside his home with an empty medication bottle lying nearby. According to his family, the victim suffered from chronic pain after being injured in a motor vehicle crash several years earlier. He was prescribed methadone to control the pain and was noted to abuse his medication. This addiction to prescription medication led to the victim using crack cocaine as well. The victim had been diagnosed with bipolar disorder and was receiving treatment. He was described as depressed in the weeks leading up to his death due to his addiction, which had resulted in financial problems. The victim had attempted suicide in the past but the method is not known. The victim did not leave a note.



ADULT PROTECTIVE SERVICES

Several reports were made due to self-neglect and concern from the victim's family. The victim was known to have a long psychiatric history and was not compliant with his medication. The victim had been involuntarily committed on several occasions and attempted suicide twice by overdose. The reports were substantiated and the victim last had contact with the Department of Social Services a year prior to his death.

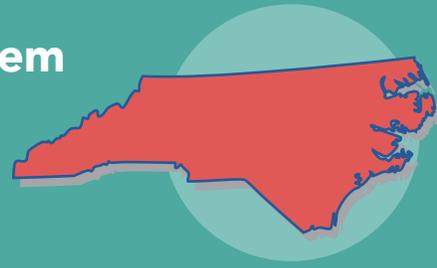


NORTH CAROLINA Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the North Carolina Division of Public Health,
Injury & Violence Prevention Branch

Collecting data since 2004



THE BIG PICTURE

Elder maltreatment is an increasing problem across the U.S., and this maltreatment may contribute to suicide and homicide among older adults. Data from the North Carolina Violent Death Reporting System (NC-VDRS) show that **for the 652 elder North Carolina residents who died as a result of violence from 2008 to 2009,**

- 530 (81%) were suicide-related,
- 34% of all elder males and 48% of elder females had been characterized as having a current mental health problem by a medical professional, and
- 32% of males and 31% of females disclosed their intention to commit suicide to someone else.

Older adults, disabled adults and disabled emancipated minors served by North Carolina's Adult Protective Services may be particularly vulnerable to abuse and neglect, and at risk for a violent death.

81%

of the **652** elder deaths from violence in 2008-2009 were suicide-related

TRANSLATING DATA INTO ACTION

Few states have surveillance systems which allow them to adequately understand the magnitude of elder maltreatment in their state. **North Carolina improved its elder maltreatment surveillance by linking data from the North Carolina Violent Death Reporting System (NC-VDRS) with records from the Division of Aging and Adult Services' Adult Protective Services (APS),** which works through 100 county social services departments to identify and serve adults in need of protective services.

New linked data

North Carolina quantified and described – **for the first time** – violent deaths among persons age 18 and above in care of APS. During 2005-2008:

- Most APS deaths were among females, **but males accounted for over 60% of violence-related APS deaths.**
- **Violence-related APS deaths occurred most often among persons ages 45-54,** while all other types of APS deaths occurred most often over age 75.
- Among adults in APS care who died from suicide, over 70% were identified as having a mental health diagnosis and almost 70% were receiving treatment at the time of their death.

Case-level data

Linking NC-VDRS and APS data provided important case-level information, including if the person had ever been or was currently in APS care at the time of death, and if so, the county social service involved at the time of death, the length of time in this care, and the type of protective services received.

Targeted services & improved programs

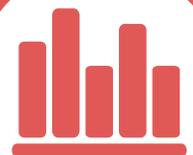
The Division of Aging and Adult Services used the linked data to work with APS in counties where these deaths occurred to **better target elder maltreatment prevention programs and improve staff training to identify violent death risks,** such as indications of suicidal ideation or prior attempts.

New adult fatality review process

Based on its collaboration with the NC-VDRS, the Division of Aging and Adult Services is **developing an adult fatality case review protocol and data collection process** that will be conducted for every adult in APS who dies.

NC-VDRS & APS data linked for the first time

APS can better target elder maltreatment prevention programs



Adult Fatality Case Review will be conducted for every adult who dies in APS care

OHIO Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Ohio Department of Health,
Violence & Injury Prevention Program

Collecting data since 2010



ESTABLISHING OHIO'S VIOLENT DEATH REPORTING SYSTEM



OHIO Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Ohio Department of Health,
Violence & Injury Prevention Program

Collecting data since 2010



A LEGISLATIVE APPROACH TO ESTABLISHING THE OH-VDRS

To establish the Ohio Violent Death Reporting System (OH-VDRS), the Ohio Department of Health determined that legislation that mandates reporting by key data providers – including coroners and law enforcement agencies – was a necessary first step.

CHALLENGES

Like many states, Ohio has no centralized coroner or law enforcement data systems. Prior to the OH-VDRS, a request for data about a death had to be made to one of 88 county coroners, and at least one of the state's 900+ local law enforcement agencies.

Existing state laws regarding confidentiality presented challenges for establishing the OH-VDRS, including Ohio's Sunshine Laws (Public Records Law & Open Meeting Acts), which allow any person to make a request for information; law enforcement records that remain confidential while a death is under investigation (for homicides, this may take years); and coroner records, which include investigative notes that may remain confidential, while other coroner data are made public.

PARTNERSHIPS

Partnerships with coroners, medical examiners and law enforcement agencies – and the professional associations representing these partners – were central to the successful passage of the legislation.

To educate partners, the Violence & Injury Prevention Program (VIPP) provided information about the OH-VDRS to coroners, law enforcement and others. Partners supported the OH-VDRS and recommended a legislative approach once they understood how their data would be kept confidential and used for violence prevention efforts (not typical prior to the OH-VDRS). They also valued being able to share county-level data from the OH-VDRS with prevention partners in their communities.

The OH-VDRS Advisory Board included representatives from coroner and law enforcement associations, who spoke on behalf of the OH-VDRS during legislative hearings.

Legal counsel from the Ohio Department of Health helped the VIPP to draft model language. Staff from the department's Office of Government Affairs helped to identify potential legislative paths for the OH-VDRS legislation (e.g. state biennium and mid-biennium budget bills) and respond to requests about the legislation.

LEGISLATION

After multiple attempts over two years, legislation was passed that (1) established the OH-VDRS, (2) authorized the Ohio Department of Health to study and collect violent death data, (3) mandated reporting from key data sources relevant to the OH-VDRS, and (4) deemed all data collected and subsequent work products to be confidential and exempt from public record requests.

IMPACT OF LEGISLATION & MANDATED REPORTING

Ohio's legislation requiring confidential, mandated reporting contributed to the credibility and effectiveness of the OH-VDRS. The legislation:

- supports the OH-VDRS when it requests data from coroners, medical examiners and law enforcement, and supports coroners and law enforcement when they release data to the OH-VDRS;
- ensures that data collected for the OH-VDRS will be used for valid public health reporting purposes; and
- has resulted in high participation rates – almost 100% among coroners and about 80% among law enforcement – which in turn help ensure OH-VDRS's long-term sustainability.

THE BIG PICTURE

Prior to establishing the OH-VDRS, the Violence & Injury Prevention Program (VIPP) had little data to support its assumptions about different kinds of violent deaths. Now the state has important information about violent deaths. For example:

- In 2010, there were 2,192 violent deaths in Ohio.
- 65%, or nearly two-thirds, of these violent deaths were suicides.
- About 25% of these deaths were homicides.

OH-VDRS data also includes information about the circumstances of violent deaths. With these data, the VIPP has evidence that:

Among women who died from homicide

- 54.2% of these deaths were related to intimate partner violence.

Among persons who died from suicide

- 41.3% were currently depressed,
- 53.1% had a current mental health problem,
- 21.7% had a previous suicide attempt, and 30.8% had disclosed their intent to someone.

54%

of homicide deaths among women were related to intimate partner violence

RHODE ISLAND Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Rhode Island Department of Health
Center for Health Data and Analysis and Office of State Medical Examiners

Collecting data since 2004



DEATH CERTIFICATE

- 43-year-old white male victim
- Divorced, unemployed
- Died at home due to asphyxiation from hanging



TOXICOLOGY

- Victim had a Blood Alcohol Concentration of 0.32

LAW ENFORCEMENT

- Neighbor saw victim hanging in garage
- Ex-wife stated victim had history of alcoholism & their divorce was finalized one week ago

A SUICIDE IN RHODE ISLAND

The example below tells the story of a *typical* suicide in Rhode Island, but to ensure confidentiality, it is not the story of an actual death. The example was created to illustrate the violent death data typically collected and linked in the Rhode Island Violent Death Reporting System (RIVDRS).

DEATH CERTIFICATE

The victim was a 43-year-old white male who lived in a suburb in central Rhode Island. He was a divorced, unemployed machinist. He died at home due to asphyxia from hanging. The manner of death was suicide.



MEDICAL EXAMINER/ CORONER

The 43-year-old, white male victim died from asphyxia due to hanging. He had a tattoo of the Road Runner on his lower left forearm and a tattoo of a knife over his heart. He had ligature marks under and around his neck. The investigator reports the victim was found hanged in his garage where there were numerous empty beer cans scattered around. The victim's friend reports the victim had recently lost his job and recently been divorced.



LAW ENFORCEMENT

Law enforcement responded to the victim's home when a neighbor notified law enforcement that when he was returning a tool he borrowed from the victim, he noticed the victim hanging in the victim's garage. While law enforcement were investigating, the victim's ex-wife arrived on scene and stated that a week prior their divorce had been finalized. The victim's wife also stated that she had left him because he stopped going to treatment for his alcoholism. She stated the victim would become violent when he drank and she thinks his drinking also caused him to lose his job. She said he has a history of depression and had been treated for it in the past. She also stated he had no past history of suicide attempts or ideation. A note was found where the victim stated he felt worthless and could not go on without his family.



TOXICOLOGY

Toxicology reports showed the victim had a Blood Alcohol Concentration of .32. There were no other drugs in his system.



MEDICAL RECORDS

The victim had been treated for depression several years earlier and had no history of suicide ideation or attempts.



RHODE ISLAND Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Rhode Island Department of Health,
Injury & Violence Prevention Program

Collecting data since 2003



THE BIG PICTURE

In Rhode Island during 2010, there were 165 violent deaths: 135 suicides, 26 homicides and 4 deaths of undetermined manner. The number of suicides in Rhode Island peaked in 2010, declining from 102 suicides in 2011 to 89 in 2012, based on provisional 2012 data.

RIVDRS data for 2004-2010 show that:

- During this seven year period, there were a total of 731 suicides in Rhode Island.
- Males (78%) were far more likely to commit suicide than females (22%).
- Male and female suicide deaths peaked in the age group 45-54 years.
- There were 18 suicides among those aged less than 18 (15 males, 3 females).

- Just over half (52%) of those who died by suicide had a current mental health problem, and 43% were currently receiving mental health treatment.
- Nearly one in five (18%) of those who died by suicide experienced an intimate partner problem.
- 25% of those who died by suicide experienced a crisis in the two weeks prior to death.
- Only 37% of those who died by suicide left a note.

25%

of those who died by suicide experienced a crisis in the two weeks prior to death.

TRANSLATING DATA INTO ACTION

Data from the Rhode Island Violent Death Reporting System (RIVDRS) provided new information on suicide and a better understanding of who is at risk.

- RIVDRS data were used by the Department of Health's Violence & Injury Prevention Program and its prevention partners for **ground-breaking priority setting and program planning**.
- Using new suicide data from the RIVDRS, the Suicide Prevention Subcommittee of the Rhode Island Injury Community Planning Group **identified the adult, working age population as being at increased risk for suicide and suicide attempts**.
- The **data were shared with key partners** through the subcommittee's members, including the State Medical Examiner, RIVDRS Program Manager and Epidemiologist, Violence & Injury Prevention Program manager, and representatives from the Samaritans, American Foundation for Suicide Prevention, community health and mental health centers, Bradley Children's Hospital, Brown University, Coastline Employee Assistance Program, and the Rhode Island Student Assistance Program.

- An **"Economic Impact of Depression and Suicide in the Workplace"** symposium, co-sponsored by the Violence & Injury Prevention Program and Coastline Employee Assistance Program, **increased awareness** of depression and suicide among working age adults and **provided strategies for integrating suicide prevention into worksites**.
- **Symposium participants included high-level managers and human resource representatives from the two largest employers in Rhode Island.**
- **Coastline Employee Assistance Program integrated suicide prevention into its mission statement and now provides training in early identification and referral of at risk employees to their clinical staff as well as their clients.**

RIVDRS data show working age adults are at increased risk for suicide

RIVDRS shares data with suicide prevention partners & 2 of state's largest employers



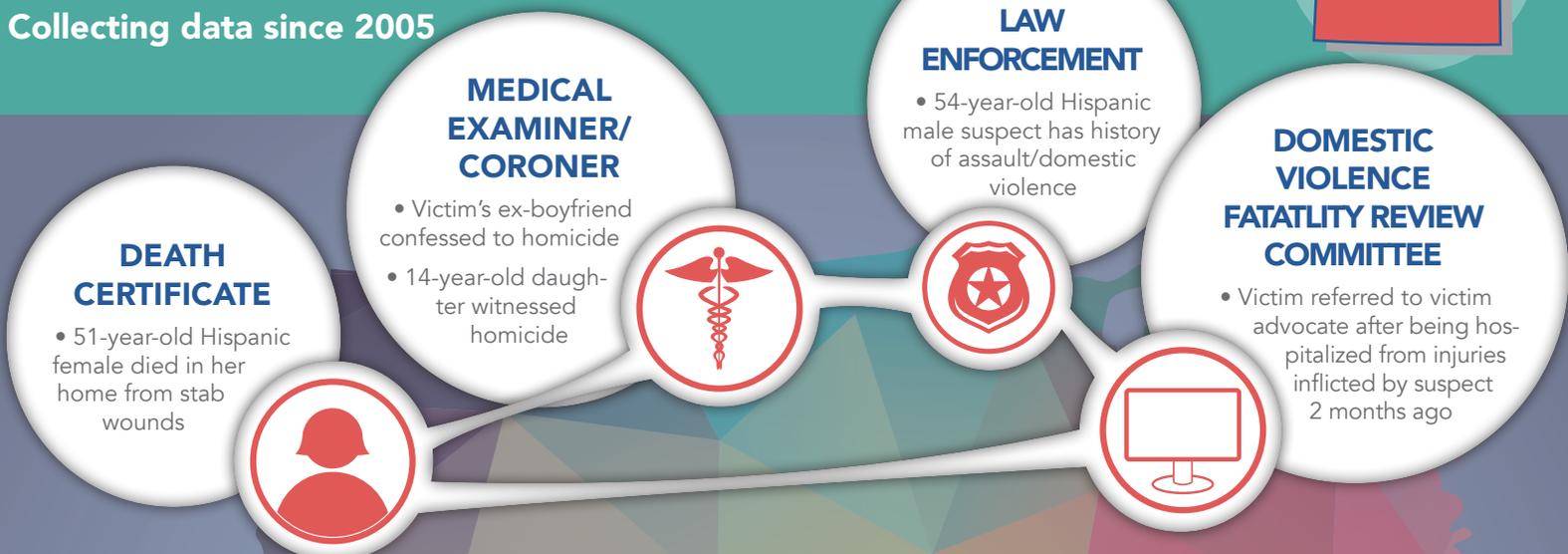
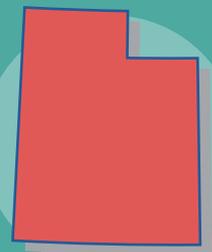
Employee assistance program adds suicide prevention to its mission, refers at-risk employees to clinical staff

UTAH Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Utah Department of Health, Violence & Injury Prevention Program

Collecting data since 2005



A DOMESTIC VIOLENCE HOMICIDE IN UTAH

The example below tells the story of a typical domestic violence-related homicide in Utah, but to ensure confidentiality, it is not the story of an actual death. The example was created to illustrate the violent death data typically collected and linked in the Utah Violent Death Reporting System (UTVDRS).

DEATH CERTIFICATE

A 51-year-old Hispanic female died at her residence. She was stabbed five times in her abdomen with a large kitchen knife. The manner of death is homicide.



MEDICAL EXAMINER/ CORONER

The victim was a 51-year-old Hispanic female who died from five stab wounds to her abdomen. The suspect used a kitchen knife to stab the victim. The death was determined to be a homicide.



Emergency medical services responded to the victim's residence early this morning. The call was made by the 14-year old daughter of the victim and the suspect, a 54-year-old Hispanic male, who is the victim's ex-boyfriend. The suspect confessed to their daughter that he had stabbed the victim.

The 14-year old daughter indicated that the victim was afraid of the suspect and overheard her mother telling a friend that he would kill her one day. The victim was no longer interested in the suspect and was planning on getting married to another man. The victim indicated that this news upset the suspect, but that he just needed time, would soon accept her decision to re-marry, and would then leave her alone.

The victim also had three fractures in her arm and bruises on her back in various stages of healing. Toxicology reports indicate that the victim had no substances present.

LAW ENFORCEMENT

The suspect is a 54-year-old Hispanic male. The victim and suspect were reported as arguing early this morning. Witnesses at the scene indicated they saw the suspect at the victim's home several times in the past few days. Once, the victim and suspect were seen fighting in the yard; the suspect slapped the victim and then immediately left.



The suspect had a long criminal history with several charges relating to assault and domestic violence in the presence of a child. The suspect's criminal history shows an escalation in violence-related charges over the past year. The last incident occurred five weeks prior to the victim's death.

Two months prior, the suspect assaulted the victim, who required hospitalization due to the assault. The suspect confessed to clergy that he had assaulted the victim two months prior.

DOMESTIC VIOLENCE FATALITY REVIEW COMMITTEE

The suspect stalked and harassed the victim. Two months prior to her death, the victim was referred to a victim advocate after she was hospitalized for injuries inflicted by the suspect. The victim was advised to seek domestic violence shelter services. The victim received relocation funds for a new apartment after the assault. For the homicide, the Office of Crime Victim Reparations paid for counseling and mental health services for the 14-year old daughter and for costs of the victim's funeral. The suspect pleaded down from manslaughter (First Degree Felony) to a Second Degree Felony.

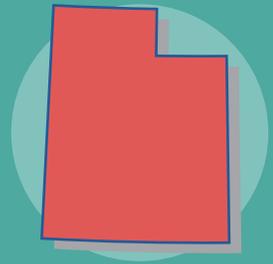


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THE BIG PICTURE

Domestic violence is one of the fastest growing violent crimes in Utah. Findings from the 2010 publication, *Domestic Violence Fatalities in Utah, 2003-2008*, by the Utah Department of Health's Violence and Injury Prevention Program and the Domestic Violence Fatality Review Committee, include:

- 1 out of 3 adult homicides are domestic violence homicides.
- Females are 10 times more likely than males to die from domestic violence.
- The majority of domestic violence homicides are committed by males.
- While Hispanic persons comprise only 10% of Utah's population, they account for 77% of domestic violence victims.
- 52% of intimate partner homicides were premeditated.
- One-third of domestic violence perpetrators committed suicide after committing a homicide.

- 91% of the domestic violence-related suicide victims experienced a crisis prior to the incident or faced an impending crisis – the most common of which was facing a criminal legal problem such as a recent or impending arrest, police pursuit, or an impending criminal court date (32.7%).
- In 44% of intimate partner violence incidents, one or more children under age 18 were living at the victim's home at the time of the incident (76 children total).
- 147 children under age 18 were directly exposed to the homicide – they saw it, heard it through the walls, were attacked or threatened during the incident, or discovered the body. Of these children, 78% were 5 years old or younger.

78%

of the **147** children directly exposed to a homicide in 2003-2008 were age **5 or younger**

TRANSLATING DATA INTO ACTION

Better data provide more complete picture of domestic violence deaths

A decade ago, it was difficult to know the extent of domestic violence in Utah because of limited data. The Utah Violent Death Reporting System (UTVDRS) has developed a more complete picture of domestic violence and its tragic impact on men, women, and children by:

- fostering a strong partnership between the Utah Department of Health's Violence and Injury Prevention Program (VIPP) and the state's multi-disciplinary Domestic Violence Fatality Review Committee (DVFRC), which includes more than 9 agencies,
- **expanding domestic violence data collection beyond the victim and suspect to include any intimate partner, family member and/or roommate involved in the incident,**
- **combining national and state-specific intimate partner violence variables** to enable the UTVDRS to collect more – and more detailed – domestic violence-related data, and
- linking data in the UTVDRS to identify and review – for the first time – when a domestic violence suspect committed suicide after the homicide.

Linking children of victims to needed services

Intimate partner violence is particularly damaging to children who witness this violence. They are at greater risk of developing psychiatric disorders, developmental problems, school failure, violence against others, and low self-esteem, and younger children typically display higher levels of distress than do older children.

Through their collaboration on the UTVDRS, the VIPP and DVFRC helped inform a policy change to close a gap in services for the children of domestic violence-related homicide victims.

- Following recommendations from a Domestic Violence Fatality Recommendations Symposium, the VIPP and DVFRC worked with the state Department of Children and Family Services (DFCS) to increase immediate referrals to DFCS at the time of a homicide – usually by law enforcement investigating the death – if the victim or perpetrator has one or more children in the home, regardless if a child was present during the incident.
- These **referrals enabled these children and their families to receive an assessment and get connected to intervention and follow-up services**, such as mental health services, to help cope with the homicide and other domestic violence-related issues.
- A referral to DFCS was made in 13 (46%) of the 28 intimate partner violence incidents with children in the home during 2003-2008.

UTVDRS data expanded to include any intimate partner, family member or roommate in incident

Worked with state DFCS to close gap in services for victim's children



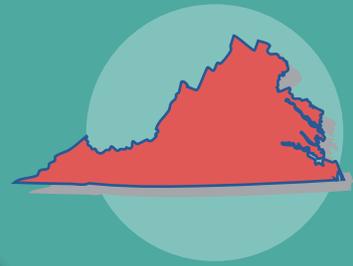
Children of victims now connected to mental health & other services

VIRGINIA Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Virginia Department of Health,
Office of the Chief Medical Examiner

Collecting data since 2003



DEATH CERTIFICATE

- 82-year-old white male
- Widowed veteran
- Suicide



MEDICAL EXAMINER

- Suffering from lung cancer
- Had stopped chemotherapy
- Taking pain medication



LAW ENFORCEMENT

- 2 bottles of prescription pain meds on counter
- Suicide note left by victim
- Victim's daughter said her father would kill himself if cancer got bad again

A SUICIDE IN VIRGINIA

The example below tells the story of a *typical* suicide in Virginia, but to ensure confidentiality, it is not the story of an actual death. The example was created to illustrate the violent death data typically collected and linked in the Virginia Violent Death Reporting System (VVDRS).

DEATH CERTIFICATE

The victim was an 82-year-old white man who lived in a small rural community in Southwest Virginia. He was a U.S. citizen born in North Carolina. He was a widowed veteran and a retired truck driver for a regional supermarket chain. He died at home from a gunshot wound to the head. The manner of death was suicide.



MEDICAL EXAMINER/ CORONER

The victim died from a gunshot wound to the head. Entrance and exit wounds reveal a single intra-oral shot using a revolver. Other pathological diagnosis included lesions on his right lung and a history of surgical removal of the lower lobe of the left lung. The victim had a tattoo with a U.S. Navy 1949-1951 anchor on his right forearm. Bruising on his forehead at autopsy suggested that he had fallen and hit his head near the time of his death. Medical records revealed that he was suffering from lung cancer, had stopped receiving chemotherapy, and was recently referred to a pain management specialist because he was frustrated with his level of pain. Pill counts revealed he had taken one dose of Oxymorphone and one of Percocet.



LAW ENFORCEMENT

Law enforcement was called to the victim's home when a neighbor reported that she had not seen him for a few days. His car was in the driveway. Law enforcement responded for a welfare check and discovered a mildly decomposed body on the living room floor of the home with a revolver lying near the right side of his body. The home was locked and secure. Law enforcement described the home as clean and neat with no evidence of foul play or intrusion. Notes on a nearby table provided post-mortem instructions on bills and funeral arrangements and a copy of his will. Two bottles of prescription medicine, one for Oxymorphone and one for Percocet, were found on the kitchen counter. Law enforcement interviewed the victim's daughter who reported that her father had been diagnosed with a recurrence of lung cancer five months ago and complained about significant pain. He had told family and friends repeatedly that if his cancer ever got bad again, he would just end it. The daughter reported that her father had no history of mental health problems and that he did not like to take pain medications because it made him sleepy and caused him to lose his balance.



TOXICOLOGY

Toxicology studies revealed that the victim did not have any opiates in his blood, but did have a Blood Alcohol Concentration of .028. Medical records showed that he had gone to a pain specialist who prescribed Oxymorphone and Percocet.

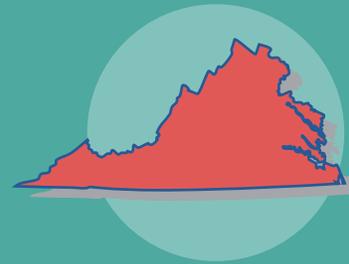


VIRGINIA Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Virginia Department of Health,
Office of the Chief Medical Examiner

Collecting data since 2003



THE BIG PICTURE

Elder suicide is a complex social problem that is often overshadowed by a focus on suicide among youth, college students or veterans. Data from the Virginia Violent Death Reporting System (VVDRS) show that:

- **elders have a higher suicide risk** (rate of 15.6) than non-elders (rate of 10.7);
- elder men are 6 times more likely than elder women to die from suicide, and **as elder men age, their suicide rate increases while it decreases for elder women;** and

- elder and non-elder suicides **differ notably in the circumstances and life events that lead to suicide**, including the presence of mental and physical health problems.

Suicide rates **increase** for elder men as they age, but **decrease** for elder women

TRANSLATING DATA INTO ACTION

A new picture of elder suicide

Combining data sources through the VVDRS enabled the Virginia Department of Health to:

- develop a **new and more complete picture of elder suicide** by exploring it as a separate and unique phenomenon;
- **identify what makes elder suicide fundamentally different** from non-elder suicide – including life altering events such as a change in marital status, onset of illness, loss of capacity for independent living, and mental and physical health problems;
- **make recommendations for where to target prevention efforts**, particularly among older men; and
- conclude, in its report *Elder Suicide in Virginia: 2003-2010*, that **elder suicide is an issue that can only be addressed by treating it as distinct from non-elder suicide.**

Regional summits increase resources

- Spurred by the release of the VVDRS data, the Virginia Department of Behavioral Health and Developmental Services – a key partner and VVDRS Advisory Committee member – funded **7 regional suicide summits** to bring together mental health, public health and other violence prevention advocates for a day of suicide prevention planning.
- In each region, Department of Health staff used VVDRS data to give a tailored data presentation on suicide. Summit participants then looked at state and local resources and **developed a regional suicide prevention plan** to address at-risk populations and the specific circumstances associated with suicide in their communities.
- Based on VVDRS data and the momentum generated by the regional summits, the Virginia Department of Behavioral Health and Developmental Services requested and **received funding for a state suicide prevention coordinator to address suicide issues across the lifespan.**

Educating through data

- In response to frequent media and community-level requests for data, VVDRS staff have provided data, radio and newspaper interviews, and **education around the fact that suicide is more common than homicide in Virginia** – a fact that often surprises those requesting the data.
- Since the VVDRS began publishing its data, staff has seen **a jump in requests** – from about 3 to 30 per year.
- With the VVDRS, the Department of Health can respond with more robust, useful and finely-tuned information – including the circumstances, methods of fatal injury, and risk factors related to violent deaths that **enable communities to hone in on specific local issues and inform the work of their prevention specialists.**
- **Specialized VVDRS reports** on the circumstances of a particular type of violent death – such as who dies at work and the issue of suicide among military members – have garnered extensive interest from the media, data users and stakeholders.

VVDRS data show elder suicide is fundamentally different from non-elder suicide

Regional suicide prevention plans developed via 7 summits



State suicide prevention coordinator hired by state mental health agency

ACKNOWLEDGEMENTS

STORIES FROM THE FRONTLINES OF VIOLENT DEATH SURVEILLANCE

Safe States Alliances thanks the individuals who contributed to *NVDRS: Stories from the Frontlines of Violent Death Surveillance*.

State health department staff in six states contributed their time to gather and share information, data and their experiences with the NVDRS and their state violent death reporting systems. Their effort made this document possible. They are listed below, along with their contact information.

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