

# FATALITY REVIEW REPORT



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# INFORMATIONAL OVERVIEW

The Summit County Domestic Violence Fatality Review Committee (the Committee) is a sub-committee of the Summit County Domestic Violence Council. The Committee operates in alignment with Ohio Revised Code 307.651, which authorizes multidisciplinary reviews of domestic violence fatalities to identify systemic gaps, improve community responses, and prevent future loss of life.

The Committee's work is not intended to assign blame or reinvestigate cases. Instead, it focuses on learning from fatalities to strengthen policies, practices, and coordination across systems that serve individuals impacted by domestic violence.

## Committee History and Re-Establishment

The Committee reconvened in the fall of 2024 after not reviewing cases for more than 15 years. During this initial phase, members focused on re-establishing the Committee's structure, developing operating guidelines, and identifying best practices grounded in national fatality review standards.

Collectively, the Committee determined that resuming case reviews was a critical step in addressing the increasing severity and lethality of domestic violence in Summit County. The Committee agreed to begin reviewing cases from 2020 onward, recognizing the impact of evolving risk factors, systemic barriers, and community responses in recent years.

## Case Review Process

The Committee officially reviewed cases in the fall of 2025. For this inaugural review cycle, the Committee examined four domestic violence-related fatality cases from 2020-2022. Reviews were conducted through a multidisciplinary lens, drawing on aggregated information from participating systems to identify:

- Missed opportunities for intervention
- Gaps in policy, practice, or coordination
- Strengths within the community response
- Actionable recommendations to reduce future fatalities

**The Summit County Domestic Violence Fatality Review Committee is comprised of representatives from key systems involved in prevention, intervention, investigation, and survivor support. Participating agencies include:**

Akron Police Department

Hope & Healing Survivor Resource Center

Summit County Medical Examiner's Office

Summit County Prosecutor's Office

Summit County Public Health Department

Summit County Sheriff's Department

Victim Assistance Program

# OVERVIEW OF CASES REVIEWED

A domestic violence fatality may include:

**Intimate partner homicide**

Death caused by a current or former spouse, dating partner, or intimate partner

**Family or household member homicide**

Death caused by a family or household member as defined under Ohio law

**Murder-suicide incidents**

When an offender kills an intimate partner or family member and then dies by suicide

**Suicide linked to domestic violence**

Death by suicide where domestic violence, coercive control, or ongoing abuse is a contributing factor

**Collateral deaths**

Deaths of third parties, including children, family members, friends, or bystanders, that occur during a domestic violence incident

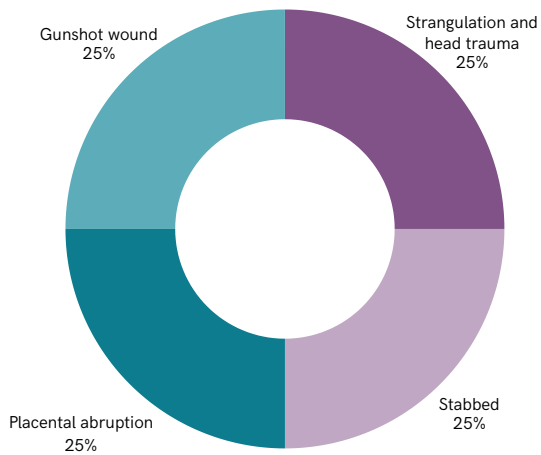
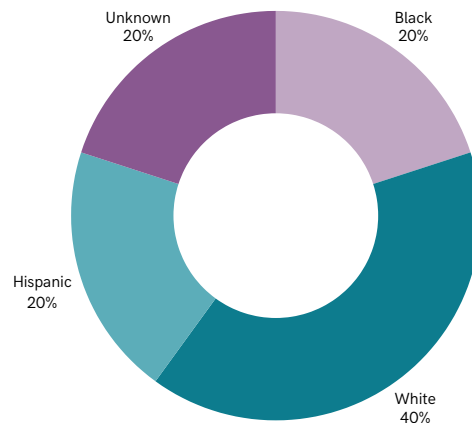
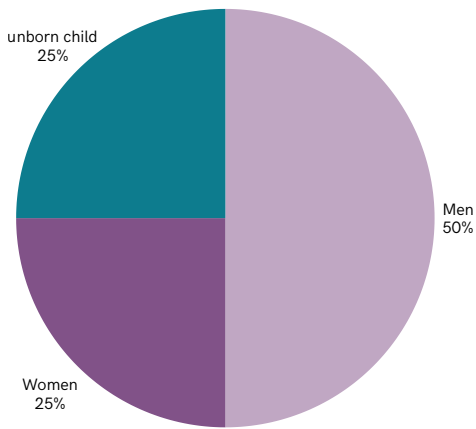
**Deaths with domestic violence indicators**

Cases involving prior abuse, protection orders, stalking, threats, separation, or recent system involvement

**Why Fatality Reviews Matter**

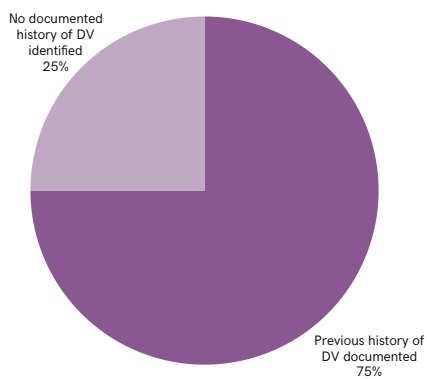
Domestic violence fatalities are rarely caused by a single event. They often reflect missed opportunities across systems over time. Fatality reviews allow communities to examine these patterns, identify gaps, and strengthen coordinated responses to prevent future loss of life. This process honors those who have died by using their stories to drive accountability, improve systems, and support safer outcomes for survivors.

## 4 Cases Reviewed from 2020-2022 VICTIM DEMOGRAPHICS



**50%**  
VICTIMS  
ENGAGED  
WITH  
COMMUNITY  
-BASED  
SERVICES  
BEFORE  
DEATH

## OFFENDER DEMOGRAPHICS



**100%**  
OFFENDERS  
ARRESTED &  
SENTENCED  
TO PRISON

# KEY FINDINGS & RECOMMENDATIONS

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## Strengthen Parole Officer Training

- One case highlighted the need for additional training for state parole officers on domestic violence dynamics. The offender reengaged in domestic violence immediately after release from incarceration for a prior DV offense, resulting in the victim’s death.

## Improve Primary Aggressor Identification in Same-Sex Cases

- Expanded training opportunities can strengthen criminal justice professionals’ ability to identify the primary aggressor in same-sex domestic violence cases.

## Increase Awareness of Survivor Services

- Only one homicide victim was documented as accessing survivor services prior to being murdered, underscoring the need for broader community education and outreach.

## Adopt High-Risk Assessment and Response Models

- Summit County should explore implementing the DA-LE risk assessment and High-Risk Domestic Violence Teams to identify and intervene with offenders at elevated risk of DV-related homicide. Offenders in the reviewed cases had violent histories prior to committing homicide.
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## FIVE YEARS OF DOMESTIC VIOLENCE RELATED HOMICIDES IN SUMMIT COUNTY

