

DOMESTIC VIOLENCE CASE INVESTIGATION FORM

(SEE NARRATIVE FOR DETAILS)

OFFICER NAME:	OFFICER #:	OFFICER AGENCY:	CR#:
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PREDOMINANT AGGRESSOR: 18-6-803.6 (2)

If a peace officer received complaints of domestic violence from two or more opposing persons, the officer shall evaluate each complaint separately to determine if a crime has been committed by one or more persons. In determining whether a crime has been committed by one or more persons, the officer shall consider the following.

(a) Any prior complaints of domestic violence

(c) The likelihood of future injury to each person

(b) The relative severity of the injuries inflicted on each person

(d) The possibility that one of the persons acted in self-defense?

SELF-DEFENSE CONSIDERATIONS (see narrative)

Is there evidence to support fear of being harmed? Was the harm imminent? Does the evidence support the responding force as reasonable? What is the relative size and strength between the two parties?

Law Enforcement determined the Predominant Aggressor is (See Narrative): _____

THE SCENE

Evidence Collected: Photographs: <input type="checkbox"/> Suspect <input type="checkbox"/> Victim Voluntary Statements: <input type="checkbox"/> Suspect <input type="checkbox"/> Victim <input type="checkbox"/> Neighbors <input type="checkbox"/> Children <input type="checkbox"/> Other: _____ Weapons? <input type="checkbox"/> Yes, <input type="checkbox"/> No If yes, what? _____	Property: Property Damage Present? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the approx. value? _____ Property in Disarray? <input type="checkbox"/> Yes <input type="checkbox"/> No	Children: Were Children Present? <input type="checkbox"/> yes <input type="checkbox"/> No If yes, Location of children: _____ <input type="checkbox"/> Involved <input type="checkbox"/> Intervened <input type="checkbox"/> Injured DHS called for this incident? <input type="checkbox"/> yes <input type="checkbox"/> No Prior DV Incidents with Children? <input type="checkbox"/> Yes <input type="checkbox"/> No
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VICTIM INFORMATION

Gender: M F Race: _____ DOB: __/__/__

Victim Behavior (as witnessed by officer): <input type="checkbox"/> Calm <input type="checkbox"/> Crying <input type="checkbox"/> Minimizing <input type="checkbox"/> Agitated <input type="checkbox"/> Involved? <input type="checkbox"/> Numb <input type="checkbox"/> Nervous <input type="checkbox"/> Afraid <input type="checkbox"/> Angry <input type="checkbox"/> Alcohol <input type="checkbox"/> Apologetic <input type="checkbox"/> Distraught <input type="checkbox"/> Reluctant <input type="checkbox"/> Threatening <input type="checkbox"/> Drugs	Victim Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No SBI Form? <input type="checkbox"/> Yes If yes, <input type="checkbox"/> Complaint of Pain <input type="checkbox"/> Minor Cuts <input type="checkbox"/> Fractures <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Lacerations <input type="checkbox"/> Concussion <input type="checkbox"/> Abrasions <input type="checkbox"/> Other: _____
Relationship to Suspect: <input type="checkbox"/> Spouse <input type="checkbox"/> Former Cohabitants <input type="checkbox"/> Same Sex Partner <input type="checkbox"/> Former Spouse <input type="checkbox"/> Dating/Engaged <input type="checkbox"/> Emancipated Minor <input type="checkbox"/> Cohabitants <input type="checkbox"/> Former Dating <input type="checkbox"/> Parent of Child from Relationship Length of Relationship? ___ years, ___ months	Description of Incident <input type="checkbox"/> Kicking <input type="checkbox"/> Slapping-Open Hand <input type="checkbox"/> Throwing Objects <input type="checkbox"/> Pushing <input type="checkbox"/> Hitting-Closed Fist <input type="checkbox"/> Violation of PO <input type="checkbox"/> Grabbing <input type="checkbox"/> Threat/Use of Weapon <input type="checkbox"/> Other: _____ <input type="checkbox"/> Biting <input type="checkbox"/> Strangulation _____

THREATS? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Verbally <input type="checkbox"/> Physically Threat: "_____"	EMERGENCY CONTACT Name: _____ Phone: _____
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AGGRAVATING CHARGING FACTORS

Pregnancy: Was the Victim pregnant at time of incident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, did the suspect know/have reason to know? <input type="checkbox"/> Yes <input type="checkbox"/> No	At Risk Adults: (18-6.5-102) Is the Victim 60 years or older? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the Victim have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
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SUSPECT INFORMATION

Suspect Behavior (as witnessed by officer): <input type="checkbox"/> Calm <input type="checkbox"/> Crying <input type="checkbox"/> Minimizing <input type="checkbox"/> Agitated <input type="checkbox"/> Involved? <input type="checkbox"/> Numb <input type="checkbox"/> Nervous <input type="checkbox"/> Afraid <input type="checkbox"/> Angry <input type="checkbox"/> Alcohol <input type="checkbox"/> Apologetic <input type="checkbox"/> Distraught <input type="checkbox"/> Reluctant <input type="checkbox"/> Threatening <input type="checkbox"/> Drugs	Suspect Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Complaint of Pain <input type="checkbox"/> Minor Cuts <input type="checkbox"/> Fractures <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Lacerations <input type="checkbox"/> Concussion <input type="checkbox"/> Abrasions <input type="checkbox"/> Other: _____
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Prior DV Behaviors

Emotional/Verbal <input type="checkbox"/> Isolation <input type="checkbox"/> Coercion <input type="checkbox"/> Threatens to take children <input type="checkbox"/> Controls money <input type="checkbox"/> Name calling <input type="checkbox"/> Threatens <input type="checkbox"/> Intimidation (looks, actions, gestures) <input type="checkbox"/> Other: _____	Physical <input type="checkbox"/> Throwing Things <input type="checkbox"/> Hitting <input type="checkbox"/> Damage Property <input type="checkbox"/> Grabbing <input type="checkbox"/> Biting <input type="checkbox"/> Other: _____ <input type="checkbox"/> Pushing <input type="checkbox"/> Kicking _____
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HIGH RISK AND POTENTIAL FOR FUTURE HARM (please check all that apply):

Per interview(s) with: _____

Severity of Violence:

Suspect has escalated violence or control
 Suspect has used severe violence
 The suspect possesses or has access to weapons.
 Guns Knives Other _____

Severity Markers

Separation (recent or past) (Stalking?) Broken Bones
 Weapons (threats with, use of) Hospitalization or ER
 Hostage Taking Alcohol or Drug Abuse
 Strangulation Death Threats
 History of Sexual Assault on Victim

Ownership:

The suspect is jealous or obsessive about victim
 The suspect is enraged or feels betrayed by victims efforts to leave
 The suspect states he will not let victim go

Failure of Community Control:

Suspect has violated a Protection Order (Stalking?) # _____
 Suspect has violated probation or parole
 Suspect has in past been restrained from contacting victim or children.
 If so, where? _____ when? _____

Anti-Social Behavior:

Suspect has prior criminal history
 Arrest for DV
 Other Assault
 Other Crime

Child Abuse
 Pet abuse

Loss of Function:

Suspect Not:
 Sleeping Eating Working

Suspect suffers from mental/emotional conditions (i.e.. Depression)
 Is taking medications Has taken medication

Suspect has threatened suicide. If so, when? _____

Suspect has made death threats.
 Victim Others Pets

STALKING: 18-3-602

Is there a current Protection Order? Yes No

(1) Repeated communication, repeatedly following, approaching, contacting or surveying PLUS either
 A. Resulting in serious emotional distress OR
 B. Credible threat (credible threat = threat, physical action or repeated conduct causing fear)

If so, investigate for felony stalking

TIP: Document evidence of serious emotional distress. i.e. Has the victim changed their phone, address, normal routines?

STRANGULATION: 18-3-202(1)(g), 18-3-203(1)(i)

Strangulation Method:

One Hand Another Body Part: _____
 Both Hands Object: _____
 Forearm

Approximate length of Strangulation: _____

Pressure of Strangulation: (on a scale of 1-10, 10 being the most pressure, how hard was the suspect's grip?) _____

Location of Strangulation Incident: _____

Strangulation Injuries:
TIP: Have the victim assess any swelling by looking in a mirror and gently feel swelling with fingers.
TIP: Look for tiny red marks (petechiae) under eyelids, behind ears and inside lips

<p>Location:</p> <p><input type="checkbox"/> Face <input type="checkbox"/> Neck <input type="checkbox"/> Above hairline <input type="checkbox"/> Eyelids <input type="checkbox"/> Shoulder <input type="checkbox"/> Chest <input type="checkbox"/> Jaw <input type="checkbox"/> Behind Ears <input type="checkbox"/> Hidden by clothing <input type="checkbox"/> Chin <input type="checkbox"/> Scalp <input type="checkbox"/> Other: _____</p>	<p>Description:</p> <p><input type="checkbox"/> Redness <input type="checkbox"/> Thumb-print bruising <input type="checkbox"/> Swelling on neck <input type="checkbox"/> Scrapes <input type="checkbox"/> Finger-print marks <input type="checkbox"/> Lumps on Neck <input type="checkbox"/> Scratch marks <input type="checkbox"/> Ligature marks <input type="checkbox"/> Bruising <input type="checkbox"/> Tiny red marks (petechiae) <input type="checkbox"/> Other: _____</p>
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The Victim experienced:

<input type="checkbox"/> Physical pain <input type="checkbox"/> Thrown against the wall/floor/ground <input type="checkbox"/> Shaken by suspect <input type="checkbox"/> Trouble breathing	<input type="checkbox"/> Trouble catching breath <input type="checkbox"/> Hyperventilation <input type="checkbox"/> Pain to the Throat <input type="checkbox"/> Trouble Swallowing <input type="checkbox"/> Pain when swallowing <input type="checkbox"/> Coughing	<input type="checkbox"/> Need to clear throat <input type="checkbox"/> Changing pitch of voice <input type="checkbox"/> Raspy voice <input type="checkbox"/> Hoarseness <input type="checkbox"/> Dizziness <input type="checkbox"/> Faintness	<input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> "Saw Stars" <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Involuntary Urination <input type="checkbox"/> Involuntary Defecation
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Investigating Motive and Intent: (describe in narrative)

TIP: Ask the Victim:

What did the suspect say? What was the suspect's facial expression and demeanor? If an object was used, was the object brought to the crime scene from another location? What caused the suspect to stop? What did you think was going to happen? What did you say? What did you do?