Contra Costa County Domestic Violence Death Review Team Report November 2005

History of Domestic Violence Death Review Teams

Domestic Violence Death Review Teams began in the early 1990's, with San Francisco and Santa Clara Counties doing some of the earliest reviews. Domestic Violence Death Review Teams (DVDRTs) now exist nationally with each state establishing statutes that mandate or recommend the formation of DVDRTs. The California Penal Code, sections 11163.3-11163.5, defines DVDRTs design protocol for our State and addresses a variety of issues related to participants and confidentiality.

DVDRTs team members have been and continue to be encouraged to participate in statewide or national DVDRTs trainings and conferences to develop the team's expertise in the death review process. On June 3, 2005, Solano County Office of Family Violence Prevention & the California Attorney General's Crime and Violence Prevention Center sponsored regional training for DVDRTs. Members of our team attended the day long training with one of our members representing our county as a panel speaker. Members of our team have also participated in The National Domestic Violence Fatality Review Initiative's annual National Conference on Domestic Violence Fatality.

Locally and nationally DVDRTs death reviews are not designed to place blame on any agency but to conduct reviews within, "a culture of safety in which domestic violence deaths are reviewed through the lens of preventive accountability." (Neil S. Websdale, et al, "Juvenile and Family Court Journal," Spring 1999, pages 61-74) Teams seek to employ models familiar in the various disciplines to review domestic violence deaths thoroughly and honestly. The intent is to systematically recognize patterns of deficiencies, and support recommendations to strengthen those areas. The intended result is to ensure such deaths are preventable.

As a team we have found areas throughout the system that have needed strengthening. Recognizing these areas it has led to recommendations to improve systems to support the reduction of domestic violence deaths within specific communities

Domestic Violence Death Review Teams are viewed as critical to improving responses to domestic violence, enhancing collaboration among involved agencies, reducing liability and saving lives. (Neil S. Websdale, "The Police Chief," July 2001, p. 65-73) The work is challenging, time demanding, and requires the diverse perspectives represented.

Contra Costa County's Domestic Violence Death Review Team

The Contra Costa County Domestic Violence Death Review Team was established in 1998. Its creation was the product of the joint efforts of Contra Costa Health Services and Contra

Costa Office of the Sheriff. Case reviews began in August 1999, following the development and implementation of operating protocols. The protocol outlines:

- goals,
- definitions,
- team membership,
- confidentiality,
- case criteria,
- procedures
- reports.

The primary goals of the DVDRT are to:

- identify potential gaps in service coordination in an effort to improve existing services delivery and policies.
- generate better domestic violence data.

Achievements of these goals will eventually diminish/reduce/prevent not only deaths related to domestic violence, but future incidents of domestic violence.

In collaboration with Contra Costa Health Services' Community Health Assessment, Planning and Evaluation Group, a computerized domestic violence death review data base has been developed for data analysis purposes. Data entry is underway, and it is anticipated that future reports will benefit from this development.

Contra Costa County's Domestic Violence Death Review Team's first report was published in November, 2000. It detailed the process of creating the Contra Costa County's Domestic Violence Death Review Team and developed case reviews from 1997. The second report was published March, 2003. It contained information from a selection of case files of deaths occurring from 1998, and 1999. Our 2005 report reviews information from case files not previously addressed 1997 to 2000. These cases have been extensively reviewed by the multi-disciplinary team, making case completion a lengthy task.

It should be noted, that case files open to adjudication are not reviewed by the DVDRT due to the legal sensitivity surrounding an open case. Therefore, case files reviewed are usually two to four years old. We currently have one case from 1998, not yet reviewed because it has not been adjudicated. We have five case files from 2000, which are still under review.

Categorization of Deaths

Basic information on each of the deaths to be reviewed is given to Domestic Violence Death Review Team members who are then asked to seek further information from their respective departments or agencies. Deaths are extensively reviewed in meetings and are categorized into one of five categories:

- **Domestic Violence Incident** Domestic violence incidents are cases in which the death occurred while current or former intimate partners were interacting with one another. For example, if one partner killed the other by running over them with a car, it would be considered a *domestic violence incident.*

- **Domestic Violence Related** Cases are considered domestic violence related if the death occurred in the midst of an episode of domestic violence but did not necessarily involve one partner killing themselves or the other partner. If one partner killed children of the other partner, or if a police officer was killed while responding to a domestic violence call, it would be considered a *domestic violence related death*.
- **Domestic Violence Motivated** Situations where a person committed suicide after the break up of a relationship involving domestic violence, or when a former partner killed their ex-partner's new partner would be considered to be *domestic violence motivated*.
- **Not Proven Domestic Violence** The DVDRT reviews cases in which a current or prior history of domestic violence is documented or suspected, but the link to the death is not clear. For example, if a person victimized by domestic violence died of a drug over-dose the death would be considered to be *not proven domestic violence.*
- **Not Domestic Violence** In some situations, original suspicions that domestic violence played a role in a person's death prove to be unfounded after further information is available. These cases are classified as *not domestic violence*, and presumably fall into the same category as the deaths in the county not reviewed by the team.

Results

Deaths Reviewed from 1997 to 2000

All told, Contra Costa County's DVDRT has reviewed 58 deaths from 1997, 1998, 1999, and 2000. One case from 1998 is pending review because it has not yet been adjudicated. Five cases from 2000 are still being reviewed. Thirty one deaths were determined to be domestic violence deaths; 23 domestic violence incidents, 7 domestic violence related, 1 domestic violence motivated. These 31 deaths involved 26 separate events involving domestic violence. Of the twenty seven other deaths reviewed, 10 were not proven domestic violence and 17 were not domestic violence. (Table 1) It is likely that some of the ten deaths classified as not proven domestic violence would be considered domestic violence cases if further information were available.

Classification	1997	1998	1999	2000	Total
DV Incident	6	7	8	2	23
DV Related	3	3	1	0	7
DV Motivated	0	1	0	0	1
Not Proven DV	4	0	6	0	10
Not DV	8	3	4	2	17
Total	21	14*	19	4*	58

Table 1: Classification of Deaths
*not all deaths reviewed for years 1998 and 2000

Of the 31 deaths involving domestic violence, 17 were males, and 14 females. All of the males were adults. Three of the females were children. Two were killed by their father who then killed himself, and one was a teen killed by her 18 year old boyfriend. There were 17 homicides, 12 suicides, 1 accidental drowning while being chased by police and 1 natural death years after a gunshot wound. Thirteen of the 14 females died of homicide, 12 at the hands of males, and one at the hand of a female intimate partner. One female committed suicide. Eleven of the 17 males committed suicide, while 4 died of homicide. Three men were killed by adult women, and one was killed by the adult son of his girlfriend. The natural death occurred in a man who had been paralyzed by a gunshot wound inflicted by his teenage step daughter. (Table 2)

	Male					Female					Total
	1997	1998	1999	2000	Total males	1997	1998	1999	2000	Total females	Grand total
Homicide	2	1	1	0	4	3	4	5	1	13	17
Suicide	2	5	3	1	11	1	0	0	0	1	12
Accidental	1	0	0	0	1	0	0	0	0	0	1
Natural	0	1	0	0	1	0	0	0	0	0	1
Total	5	7	4	1	17	4	4	5	7	14	31

Table 2: Cause of Death by Gender

Caucasians accounted for 13 of the deaths, African Americans 7, Hispanics 6, Southeast Asians 2, and Filipinos, South Asians and Native Americans 1 each. (Tables 3 and 4)

Ethnicity	Male	Female	Total
African American	4	3	7
Caucasian	8	5	13
Filipino	1	0	1
Hispanic	3	3	6
Native American	0	1	1
South Asian	0	1	1
Southeast Asian	1	1	2
Total	17	14	31

Table 3: Ethnicity of Decedent by Gender

Cause	African American	Caucasian	Filipino	Hispanic	Native American	South Asian	Southeast Asian	Total
Homicide	5	6	0	3	1	1	1	17
Suicide	1	6	1	3	0	0	1	12
Accidental	1	0	0	0	0	0	0	1
Natural	0	1	0	0	0	0	0	1
Total	7	13	1	6	1	1	2	31

Table 4: Cause of Death by Ethnicity

Of the 31 deaths determined to be domestic violence deaths, 66% involved firearms. Firearms were the method of death in 19 deaths, and the method of injury in the natural death due to complications of domestic violence related injury. They were also the method in events were someone died and 5 survivors were injured during shootings. Knives were used in 4 deaths, strangulation by hanging in 2 deaths, other strangulation, suffocation, a car and a nail gun were the method in one death each. The hangings were both suicides, as was the nail gun death. (Table 5) Additionally, 71% of the deaths occurred during times of separation (22 of 31). Twelve of these deaths were homicides and 10 were suicides.

Method	Homicide	Suicide	Total*
Car	1	0	1
Firearm	10	9	19
Knife	4	0	4
Nail Gun	0	1	1
Strangulation/Hanging	1	2	3
Suffocation	1	0	1
Total	17	10	29

Table 5: Method of Death by Cause of Death*

*Does not include deaths due to natural or accidental causes

Of the 26 domestic violence events accounting for the 31 deaths, there were ten events involving attempted/completed homicide followed by attempted/completed suicide. In nine of these cases men were responsible for the deaths; in one case a woman was responsible. Attempted/completed homicide cases accounted for 15, or nearly half, of the domestic violence deaths. They also accounted for 5 gunshot wounds to survivors. One case involved homicide in a nearby county and suicide in Contra Costa County. The total number of deaths attributable to this episode is not known. It is clear there were at least 2, though only one

occurred in and was reviewed by Contra Costa County's DVDRT. Four cases involved unsuccessful homicides and successful suicides, accounting for 4 deaths and 3 of the gunshot injuries to survivors of attempted homicide. Four cases involved a man killing his intimate partner and then himself, accounting for 6 deaths. Another case claimed three lives, a man and his two daughters, ages 1 and 3 years old. This man also injured an adult male survivor. Seven of the nine attempted/completed homicides/suicides clearly occurred during times of separation. Details of the relationships in the remaining cases were not available.

Some have questioned whether marital status influences domestic violence deaths. Thirteen of the 26 domestic violence events resulting in deaths involved people married (12 cases) or formerly married (I case) to the involved intimate partner. Seven homicides, seven suicides, and 1 natural death occurred among those married. Thirteen of the events involved people never married to the involved intimate partner. Ten homicides, 5 suicides, and 1 accidental death occurred among those not married. Children of abused women shot their mothers' intimate partner in 2 cases, one where the adult intimate partners were married, and one where they were not. Adults shot children in 3 cases, two where the adult intimate partners were married, and one where they were not. In two cases fathers shot their biological children, and in one case a man shot his step-daughter. Our data does not indicate that marital status is a significant predictor of domestic violence homicide or suicide in Contra Costa County. (Table 6)

	Homicide	Suicide	Accident	Natural	Total
Married to involved intimate partner	7	7	0	1	15
Never married to involved intimate partner	10	5	1	0	16
Total	17	12	1	1	31

Table 6: Ever Married to Intimate Partner by Cause of Death

Domestic violence deaths affect people across the life span. Children are injured and murdered, teenagers shoot adults to protect their mothers, teen relationships involve violence and sometimes death, and we are never too old to be involved in a domestic violence death. A 5 year old was shot by his father, sustaining permanent brain injury. A 15 year old was shot by her step-father, sustaining serious head injuries. Two girls under 4 were killed. A 15 year old shot her step father. At least two relationships involved teen girls abused by male partners. In one case the man drowned while fleeing police after a 911 call was placed because of domestic violence, in the other case the girl was killed by her partner. It is possible that violence occurred in other relationships prior to the deaths occurring between 18 and 24, though that information is not available. Two men over 65 died; one homicide and one suicide. (Table 7)

Age in years	Responsible for Homicide	Death by Homicide	Death by Suicide
0-5		2	0
13-17	2	1	0
18-24	4	5	2
25-40	8	3	4
40-64	3	7	4
>65	0	1	1

Table 7: Age in years by role in domestic violence episode. Those responsible for homicide and suicide are listed twice, and thus totals differ from others.

Survivors are also impacted by domestic violence deaths. Some have been physically injured. Four adults were injured in the 5 attempted homicide/successful suicide situations. Two children suffered gun shot wounds to the head. These people and others also suffer the psychological trauma of attempted murder. Many witness the homicides and suicides. In our cases, 7 minor children where left without their mother and 7 without their father. Two children were left without surviving parents. Surviving parents may be in incarcerated for the death of the other parent, another loss for children. Adult children and other family members are also impacted. People lose their children and grandchildren, sisters, brothers, extended family, friends and colleagues. Often, entire communities are traumatized by domestic violence deaths.

In one case we reviewed and categorized as "Not Proven Domestic Violence," several important issues were raised. The incident we reviewed involved a man being killed by police as he was stabbing his daughter in law. Because these two had not been intimate partners, we could not categorize it as "Domestic Violence Related," according to our definitions. However, his wife was forced to watch the stabbing, and there had been prior violence between the man and his wife, as well as the man and his daughter in law. There had been prior calls to the police by various neighbors who were aware of the violence, however there were not full reports generated by these calls. The elders in this Asian immigrant family did not speak English, and the younger folks were so frightened of and controlled by the eldest man that they denied anything was going on when officers investigated the neighbors' calls. A man died and a woman sustained life threatening and life altering injuries. Child and adult family members lived with the violence and fear, and witnessed the injury and death. Family violence occurs in multiple forms and often involves multiple family members. Cultural and language barriers present challenges in recognizing and intervening in such situations. Intervening when people seem resistant, or do not know how to ask for help, presents additional challenges.

Domestic violence deaths occur throughout Contra Costa County. Sometimes, people reside in places different than where the events occur. Antioch had 4 events and 7 deaths. One person was injured in Wyoming 9 years before his death, and one murder/suicide took 3 lives. Bay Point had 2 events and deaths. Concord had 4 events, one of a person living in Walnut Creek who hanged himself outside the Concord Pavilion, and one murder/suicide. Concord lost 4 residents. El Sobrante had one event and death. Oakley had one event that claimed 2 lives. Pittsburg had 4 events and 4 deaths. Pleasant Hill had one event and death. Richmond had 3 events and 3 deaths. San Pablo had 4 events and 5 deaths. Walnut Creek had 2 events and lost 3 residents, including the one who hanged himself at the Concord Pavilion. (Table 8)

City	Antioch	Bay Point	Concord	El Sobrante	Oakley	Pittsburg	Pleasant Hill	Richmond	San Pablo	Walnut Creek
Number	4	2	4	1	1	4	1	3	4	2

Table 8: Number of events resulting in 1 or more domestic violence deaths. One event occurred in Wyoming 9 years prior to the death in Antioch.

In twenty one of the 26 domestic violence events involving deaths, there was a history of prior domestic violence between the intimate partners involved. This was revealed by prior police reports for domestic violence, prior calls to domestic violence service agencies, or interviews of survivors at the time of the deaths. The 20 events account for 25 deaths. Males were the perpetrators of domestic violence in 19 of the 20 couples involved. In one case, there appeared to have been recurrent, mutual domestic violence. Eight of the 10 attempted/completed homicides/suicides involved relationships known to have had violent histories. In several cases, there was not adequate information to be clear whether prior domestic violence had occurred or not.

In twelve of the 26 events accounting for the 31domestic violence deaths, law enforcement or other domestic violence services had been contacted prior the deaths. The majority (54%) involved in domestic violence deaths had no known contact with law enforcement regarding domestic violence or with other domestic violence service agencies. Of the 20 cases with a known history of domestic violence, just over half (12 of 20, or 60%) had previous contact with law enforcement or other domestic violence service agencies. In the 12 cases with a known history of domestic violence and contact with law enforcement or other service agencies, there were 13 total deaths. Eight men died; 4 by suicide, 2 by homicide, and one each by accidental and natural causes. One homicide was an adult son killing the man who had been violent with him and his mother, and the other was a man killed by his estranged wife with whom he had a well documented recurrent, mutually violent relationship. Each had prior charges for abusing the other. The accidental death was a drowning while fleeing police and the natural causes was the man shot 9 years prior by his step-daughter for abusing her and her mother. Five women died, all by homicide at the hands of the men who had previously been violent with them. Eight of the attempted/completed homicides/suicides involved relationships with a known history of intimate partner violence. In only 2 cases was there a history of involvement of law enforcement or other domestic violence services. The other six cases with a known history of violence had no contact with law enforcement or other domestic violence services, and account for 10 deaths.

Few deaths involved parties protected or restrained by restraining orders. Of 26 separate domestic violent episodes that involved at least one death, only five (19%) involved parties protected or restrained by restraining orders. Three men committed suicide while restrained by a restraining order, one of whom killed his wife and injured his son prior to killing himself. One woman killed her ex-husband while she was both protected and restrained by a mutual

restraining order. In 4 of the 5 cases were restraining orders were active at the time of the domestic violence deaths, the parties had been or were currently married to one another.

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Conclusions

1. Local statistics are proving true what national data have shown: The most dangerous time of a relationship is during the time of separation.
2. Firearms were used in the majority of both homicides and suicides in domestic violence cases.
3. Children remain both direct and indirect victims of domestic violence.
4. The majority of female domestic violence deaths are the result of homicide by males. The majority of male domestic violence deaths are the result of suicide. More males die than females in domestic violence events in Contra Costa County.
5. Domestic violence deaths are not confined to any specific region of Contra Costa County.
6. Domestic violence deaths are not confined to any specific ethnic/cultural group in Contra Costa County.
7. The majority of people involved in incidents reviewed are not known to have sought services from public or private domestic violence service agencies.
8. A majority of deaths involved individuals who were neither protected nor restrained by restraining orders.
9. Marital status does not influence the risk of domestic violence death in Contra Costa County.
10. Domestic Violence can be challenging to recognize, particularly if those involved are resistant to intervention.

Recommendations

1. Recognizing that separation is a critical time, all persons working with individuals involved in violent relationships need to be aware of the potential for lethality and promote the development of a safety plan which may include:
    a. Emergency protective orders and/or restraining orders.
    b. Alternative housing and/or shelter.
    c. Appropriate referrals for all family members.
2. When restraining orders are in place and/or arrests occur, firearms should be confiscated whenever possible.
3. The safety and welfare of children should be considered, assessed and documented in all domestic violence incidents.
4. First responders should document the presence of children, assess the safety and welfare of the children, and interview children in all domestic violence incidents.
5. Community outreach and education regarding domestic violence must reflect the cultural/ethnic diversity of Contra Costa County. Services must also reflect this diversity.
6. The countywide use of the Domestic Violence Report/Supplemental by law enforcement agencies and centralized computer data entry by the Sheriff's

Department has improved significantly and is essential for agencies dealing with domestic violence. This data base must be maintained.

7. Government and private agencies must continue to develop and implement methods for identifying and coding cases involving domestic violence.
8. Multidisciplinary efforts to address domestic violence treatment and intervention should continue and be further enhanced, including, though not limited to, enhanced coordination and exchange of information between Child Death Review Team and Domestic Violence Death Review Team.
9. We recognize the value of the services provided by public and private agencies and encourage referral to and collaboration with these agencies by all involved with individuals involved in violent relationships. These agencies provide services that are essential for preventing domestic violence deaths, and require on going fiscal and political support.

Attachment 1
Death Review Team Members

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