Sacramento County

DOMESTIC VIOLENCE DEATH REVIEW TEAM

REPORT OF THE DOMESTIC VIOLENCE DEATH REVIEW TEAM OF SACRAMENTO COUNTY October, 2002

Appendix A | Appendix B | Appendix C

INTRODUCTION

The Domestic Violence Death Review Team of Sacramento County is a sub-unit of the Sacramento County Domestic Violence Coordinating Council, and also exists pursuant to the authority of Penal Code section 11163.3. Formed in the Spring of 1998, it meets on a monthly basis. This is the third annual report of the Domestic Violence Death Review Team. The first report was prepared in July 2000, and was released during Domestic Violence Awareness Month, October. The second report was released in October 2001.

PURPOSE

The purpose of the Domestic Violence Death Review Team is to bring together a multi-disciplinary team to review domestic violence deaths in Sacramento County with a view towards making recommendations to help prevent DV deaths, and develop strategies to deal with Domestic Violence.

CONFIDENTIALITY

Pursuant to Penal Code section 11163.3, the meetings of the DVDRT are confidential. Every representative of a constituent agency or institution who attends DVDRT meetings signs an agreement of confidentiality.

MEMBERSHIP

The Domestic Violence Death Review Team is designed as a multi-disciplinary, broad based organization which calls upon information from law enforcement, medical, public health, social services, legal, coroner, child welfare, and domestic violence advocacy organizations. Each agency or organization has agreed to provide at least one staff person to review and analyze cases, attend regular meetings, and assist in formulating recommendations. The constituent agencies and organizations are:

- Sacramento District Attorney's Office
- Sacramento Sheriff's Department
- Sacramento Police Department
- Folsom Police Department
- Sacramento Probation Department
- Sacramento Coroner's Office
- Law Enforcement Chaplaincy -- Sacramento
- California Attorney General's Office
- California Department of Justice Automated Systems Programs
- Sacramento Fire Department
- Sacramento County Department of Health and Human Services:
- Division of Public Health Promotion and Education
- Division of Child Protective Services
- Division of Mental Health
- Sacramento County Office of Education Prevention and Student Services
- Kaiser Permanente
- University of California, Davis, Medical Center
- Sutter Medical Center, Sacramento
- Catholic Healthcare West/Mercy Sacramento
- Women Escaping a Violent Environment (WEAVE)

IMPLEMENTATION

The Domestic Violence Death Review Team seeks to achieve its purpose through the following steps:

1. Act as a multi-agency, multi-disciplinary team with regular meetings.
2. Operate according to principals of confidentiality, which includes a signed statement of confidentiality for all team participants.
3. Maintain a database of all reviewed cases.
4. Develop and recommend strategies to help prevent domestic violence deaths.
5. Develop and recommend strategies to help in dealing with the aftermath of domestic violence and domestic violence deaths.
6. Interact with agencies and community based organizations to help achieve its goals, using the Domestic Violence Coordinating Council as a point of contact and interaction.

SELECTION AND REVIEW OF CASES

The process for the selection of cases to be reviewed has been subject to some modification during the history of the DVDRT. The initial process involved the constituent law enforcement members of the team selecting cases for the team, identifying those cases before each meeting. The other team members would then research their records for any information their organization had about the incident and/or the principle parties. Several of the constituent DVDRT members received information in a confidential or protected relationship. In many instances, this information might relate to the individual being prosecuted as the criminal defendant. Given this situation, it was recognized that the confidentiality protections associated with the DVDRT may in some instances be insufficient to prevent a conflict of interest by either the disclosing parties or the law enforcement parties. In particular, law enforcement parties might feel compelled to use any information in furtherance of the prosecution, or turn it over to other parties (i.e. the defense) in a case being prosecuted. The enabling statute resolves any issue with respect to a conflict of interest by health care or social services providers, but does not resolve the issues for the law enforcement and prosecution members of the team. In addition, since the review of such cases in the DVDRT would raise the potential of use of such information in the criminal case, it would likely lead to litigation in the criminal case as to whether any applicable evidentiary privileges had been breached through the DVDRT.

Accordingly, the DVDRT initially reviewed only cases of murder-suicide, where no criminal prosecution was possible. After a period of time, the team extended its scope to include cases where the criminal prosecution has been completed to the point of sentencing or dismissal by the time of the DVDRT review. This change in scope necessarily required the input of the District Attorney's Office in the case selection process. This led in 2001 to a shifting of Eventually, the principal responsibility for the selection of cases from the police law enforcement agencies the D.A.'s Office. Generally, cases identified for review arise from the Sacramento Police Department or the Sacramento Sheriff's Department on an alternating basis.

When a case has been selected, the D.A.'s Office and the police agencies provide identifying information concerning the victim, the perpetrator, and when applicable any involved children, in advance of the meeting. Each team member then has been responsible for reviewing the records of their agency to identify any information about the parties. At the meeting on the case, the investigating police agency first presents the circumstances surrounding the homicide. Each team member then shares the facts concerning the parties available from the constituent agency.

In some situations, the DVDRT may extend an invitation to a family representative or close friend of the parties, to provide additional insight into the dynamics of the case.

As part of the review process for the preparation of this annual report, the Team determined to modify the case selection process to assist in better examination and review of cases. A sub-committee was chosen to select cases for future review. In addition, a procedure is being developed to assign a principal person for each case, who will be responsible for making the initial basic presentation of case information, and ensuring that certain basic data is provided for the data base.

By virtue of both this selection process and time limitations, the data base findings as to the cases reviewed cannot be considered exhaustive, or statistically representative. They do reflect, nonetheless, what this team has reviewed. Appendix A reflects data compiled from the cases reviewed by the Team. In addition, this report includes in Appendix B a

basic statistical breakdown of domestic violence homicides in Sacramento County for the six year period from January 1, 1996 through December 31, 2001.

DOMESTIC VIOLENCE DEATH DATA COLLECTION

For purposes of facilitating data collection, the DVDRT developed a data collection sheet for use with each case. The purpose behind the data collection sheet was for each agency to complete that portion of the sheet for which the agency had data for a particular case. The data sheets submitted by each agency on a particular case would then be combined so that the data could be entered in a database to help analyze the information the team has reviewed. A copy of the data collection form was appended to the DVDRT report in 2000.

In practice, the actual use of the data sheet in the manner was less than consistent. In preparation for this report, the Team recognized that the data collection process as it actually occurred did not follow the procedures the Team had originally envisioned when the data collection form and its associated processes were originally designed. The Team has appointed a sub-committee to examine the process and devise a system of data collection that will realistically match procedure with practice and actual data collection. As part of that process Sacramento County Public Health Division has contributed the services of an epidemiologist to assist in revising the process and provide professional expertise in the compilation of the data.

CASES REVIEWED

As of September 2002, the Domestic Violence Death Review Team has reviewed a selected 25 cases, which occurred from 1993 to 2000. Fourteen were murder-suicides, and in one the perpetrator later committed suicide while in custody. Eleven were murders which were later prosecuted, the prosecutions having been completed (in one instance dismissed following the in-custody suicide).

Twenty cases involved the murder of more than one victim. One case involved the attempted murder of an additional victim.

In sixteen of the cases, the means of death was a firearm.

In four of the cases, the perpetrator had known previous suicide attempts.

In many cases, the team found no report to local law enforcement or social service agencies of prior domestic violence by the perpetrator. In some instances, however, the DVDRT contacts with family members, friends or other agencies revealed either prior attempts to report, or more formal contacts with other support, health, mental health, or law enforcement agencies in and outside Sacramento County. These two types of situations (i.e. no reports to local agencies, or prior attempts to report or make contact) were of concern, since agency contact could potentially have brought services to bear on the situation which may have prevented the homicide.

The team did observe instances, however, where even extensive institutional and agency contacts and the resultant availability of many services did not prevent the final fatal violence. In one troubling situation, both parties to the intimate relationship had multiple agency contacts, including medical, mental health, law enforcement, and CPS contacts. Both partners had reported domestic violence committed by the other. CPS intervention had removed the children from the home, insulating them from the potential for

becoming victims of future violence. A variety of social services were available to the parties. The plan for allowing child reunification had elements that would have kept the parties separate. In spite of these circumstances, the two parties did reunite, and fatal violence between the two then took place.

Attached to this report as Appendix A is a statistical abstract with a breakdown of various features of the 25 cases.

STRATEGIES AND RECOMMENDATIONS

A. Status of Earlier Recommendations

In both the 2000 and 2001 Reports, the team made various recommendations about strategies for dealing with both domestic violence, and domestic violence homicides. Those recommendations, and notations as to their status, are attached as Exhibit C.

B. New Recommendations

1. Availability of Shelter Beds

The DVDRT has observed with some concern that there are only 35 shelter beds available in this county for women who are attempting to find refuge from domestic violence. Given the size of this county, it appears that this is not sufficient. None of the cases the DVDRT has examined specifically involved a woman who was turned away from a shelter and then became the victim of domestic violence homicide. Still, team members are aware from their experience in the field that domestic violence victims are all too often turned away from the local WEAVE shelter because no beds are available.

The DVDRT believes this situation should be the subject of study and any appropriate remedial action. As a first step, WEAVE should be asked to keep data on the number of persons seeking shelter who they must turn away. After keeping such data, the matter should be evaluated with the goal in mind that the appropriate number of shelter beds for this community should be set. Thereafter, such action as is necessary should be taken to ensure that Sacramento County has an adequate number of shelter beds for the victims of domestic violence.

2. CPS Advisement by Law Enforcement Dealing with Domestic Violence Calls

When persons living together present the risk of physical danger, the protective actions that may be taken vary depending upon the status of the parties. One of the major distinction arises when minors are involved. When children are exposed to an unacceptable risk of physical danger, the children may be removed from the situation through Child Protective Services action, over the objection of both the parent and the child. By contrast, as between two adults living together, when one presents a physical danger to the other, the parties may still choose to live together, and ordinarily cannot be separated so long as both consent. Unfortunately, this situation sometimes leads to persons continuing to live together, through an escalating cycle of violence.

In the absence of children, there is little authorities can do to change the domestic unit when two consenting adults choose to continue to live together. When children are present, however, they may be, should be and often are removed from the violent situation. The possible removal of children is something that parties to a violent

domestic relationship should be made aware of. Advising the parties of this potential, and following through with CPS and other agencies where appropriate, can serve not only to protect the children. Hopefully, it can also be an effective means of bringing the parties to realize that they must deal with their domestic violence problem, and that their failure to do so can affect not just each other, but also their relationship with any children. Such realization may provide an added incentive to the parties to address the underlying issue of domestic violence in their relationship.

The DVDRT believes that law enforcement should be trained to make domestic violence perpetrators and victims aware of this potential consequence of domestic violence. Law enforcement regularly deals with domestic violence situations as they occur. Officers thus have a unique opportunity to emphasize to the parties the concern that society has for any children present, and the need for mandatory reporting and action to protect children. To the extent such advisement leads the parties to more seriously recognize the need to address their domestic violence problem, it can only have a positive result.

APPENDIX A
Statistical findings on the select cases reviewed by the Domestic Violence Death Review Team

SACRAMENTO COUNTY INTIMATE PARTNER HOMICIDE INFORMATION
Death Review Team findings on 25 select cases
9/30/2002

	Victim age (in years) *(Range=17 through 71; average age=35)*	**Perpetrator age** (in years) *(Range=18 through 77; average age=40)*
15-20	3	1
21-30	9	8
31-40	4	6
41-50	5	3
51-60	2	5
61-70	0	0
71 and over	1	1
Unknown	1	1
	Victim race	**Perpetrator race**
White	15	10

Black	3	4
Hispanic	3	7
Asian/ all others	3	2
Unknown	1	2

Weapon Used	**#**
Gun [(1)] *(handgun=11; shotgun=2; unspecified firearm=4)*	16
Other weapon	8
Unknown	1

(1) In one case both a handgun and shotgun were used

Multiple *(more than one victim)* **homicide**	**#**
No	20
Yes	4
Mult.V, but only one fatality	1
Homicide occurred in victim's home	**#**
Yes	22
No	3

Perpetrator and victim lived in same home	
Yes	18
No	7
Victim gender	
Male	3
Female	21
Undetermined (2)	1

Perpetrator gender	
Male	20
Female	4
Undetermined (2)	1

([2]) In one case it was not determined which of the two parties was the aggressor

Victim employment status	
Unknown	11
Not employed	7
Unknown	7
Perpetrator employment status	
Unknown	7
Not employed	8
Unknown	10
Victim educational attainment	
High school or beyond	5
Unknown	19
Relationship between victim and perp	
Spouse	17
Cohabiting	3
Co-parent	2
Dating	2
Unknown	1
Length of relationship	
0-2 years	3
2-5 years	2
6-10 years	3
10 or more years	5
Unknown	12
Relationship status	
Living together, details unknown	14
Living together, no discussion of separation	3
Living together, discussing separation	2

Separated for less than 1 year		3
Never lived together		3
Perpetrator Outcome		
Suicide		15
Other		10
Perpetrator under the influence		
Alcohol	Yes	4
	No	6
	Unknown	14
Illegal Drugs	Yes	3
	No	8
	Unknown	14
Perpetrator had previous suicide attempts		
Yes *(within 6 months=1; 6 months to 1 year=1; more than 1 year=1)*		4
Unknown		20
Previous physical violence in the relationship *(including minor violence)*		
Yes		11
Unknown		13
Children under 18 living in the household:		
Yes		12
No		13

APPENDIX B
Statistical findings on intimate partner homicides in Sacramento County, January 1, 1996 to December 31, 2001

SACRAMENTO COUNTY INTIMATE PARTNER HOMICIDE INFORMATION
January 1, 1996 through December 31, 2001

	Victim age (in years) *(Range=17 through 71; + 1 prenatal infant victim of assault on mother; avg. age = 36)*	**Perpetrator age** (in years) *(Range=16 through 77; average age=37)*
< 15	1	0
15-20	7	6
21-30	21	21
31-40	21	22
41-50	14	14
51-60	8	10
61-70	1	0
71 and over	1	1
	Victim race	**Perpetrator race**
White	33	37
Black	27	28
Hispanic	7	5
Asian/ all others	7	4

Weapon Used	**#**
Gun [1] *(handgun=31; shotgun=4; unspecified firearm=3)*	38
Other weapon	24
Unknown	14

(1) In one case both a handgun and shotgun were used

Multiple *(more than one victim)* **homicide**	**#**
No	58
Yes	24
Mult.V, but only one fatality	13
Intimate partner assaulted, not killed, but another person was killed	4
Victim gender	
Male	17
Female	55
Undetermined (2)	2
Perpetrator gender	
Male	55
Female	17
Undetermined (2)	2

([2)] In two cases it was not determined which of the two parties was the aggressor

Relationship between victim and perp	
Spouse	34
Cohabiting	19
(Other) Co-parent	3
Dating	14
Other	1
Not Clear	3
Perpetrator Outcome	
Suicide	21
Other	52
Children under 18 living in the household:	
Yes	28
No	46

The above was compiled from data submitted by the Sacramento Sheriff's Department, Sacramento Police Department, Folsom Police Department, and the Sacramento District Attorney's Office. Cases were included (1) if the perpetrator and the victim were married, cohabiting in an intimate relationship, co-parents, or dating; (2) the perpetrator assaulted his/her intimate partner; and (3) in that assaultive incident, a death occurred. If persons other than the intimate partner were victims in the same assaultive incident, it is reflected above. In two incidents, the perpetrator assaulted the intimate partner, and the intimate partner survived, but another person died. Both of these incidents are included in the data above. In one incident, additional perpetrators assisted the primary intimate partner assailant. For that case, only the demographic information concerning the intimate partner assailant has been
included.

APPENDIX C
Status of Recommendations from earlier reports by the Domestic Violence Death Review Team

2000 RECOMMENDATIONS

1. Access to Mental Health Records (2000 Recommendation)

Under current law, Domestic Violence Death Review Teams do not have adequate access to mental health records. The team recommends that the topic of access to mental health records for Domestic Violence Death Review Teams be studied, and that sufficient procedures be adopted, through legislation and other appropriate avenues, to ensure adequate access to mental health records for teams studying domestic violence cases.

STATUS: Recommendation remains open – No futher progress:
Penal Code section 11163.3, the Domestic Violence Death Review Team enabling statute, states that mental health care providers may furnish mental health records to a DV Death Review Team without suffering any liability. It does not, however, require a provider to furnish records to a team, nor does the team have any subpoena or other authority to compel production of records. The Sacramento County DV Death Review Team has at times experienced resistance by some mental health care providers to furnishing records to the team in the absence of a waiver by an appropriate party. The team has faced occasions where the health care provider had mental health records on the victim, but the mental health section of the health care provider refused to supply the records. There has been no legislative effort to amend the existing statutes.

2. Cases with Surviving Minor Children (2000 Recommendation, as modified in 2001)

In cases of domestic violence homicide with surviving children, there is usually no parent left for the child. One is the homicide victim, and the other is unavailable to surviving children because he or she is either a suicide victim or a perpetrator, drawn into the criminal justice system for the foreseeable future and thus unavailable. The DVDRT in its review of cases perceives such children are not always connected with the appropriate agencies in the manner they should be. The DVDRT recommends the following where a domestic violence death occurs and minor children are survivors:

a. Minor children present or part of a family in a home where a domestic violence homicide occurs should be interviewed immediately and separately.

b. Child Protective Services should be notified to conduct an emergency response in any domestic violence homicide with surviving children, whether or not the children were present at the scene at the time of the incident, to decide on immediate placement of the child after a domestic violence homicide. Child Protective Services should also be involved in the placement.

   Law enforcement should notify CPS immediately of any domestic violence homicides with surviving children whether or not the children were present at the scene at the time of the incident. Current practice is that law enforcement will sometimes call the CPS Emergency Response screening room or on-call ER workers after hours. The team recommends that in every case of domestic violence homicide with minor children in the household, law enforcement should call CPS (the Emergency Response screening room, or on-call ER worker after hours) and that CPS should respond forthwith in each case and make an in-person assessment and evaluation to determine appropriate further response. Consideration should be given to establishing procedures for a comprehensive evaluation of each child, like those done for foster child placement.

c. Child Protective Services should determine the appropriate follow-up needed in Domestic Violence homicide cases with surviving children. CPS shall assess the placement and/or service needs of the children and provide the necessary follow-up to reduce the risk to the children and facilitate any needed services.

d. A system should be put in place for notifying the District Attorney's Victim-Witness unit in murder-suicide cases, where the absence of a prosecution means the police report would not ordinarily go to the DA, in order to facilitate the availability of State Board of Control victim and counseling funding resources for the surviving child/children.

e. Victim-Witness should notify the guardians of all minor children, whether or not they witnessed the homicide, of the availability of victim-witness funding for counseling.

   STATUS: As to recommendations (a), (b) and (c), the procedures recommended above have been adopted, and are in place. As to sections (d) and (e), while the Victim-Witness section makes regular contact with the Homicide section of both the Sacramento Police Department and the Sacramento Sheriff's Department, institutional referrals of homicide cases from those agencies are not always made. Victim-Witness also relies on media reports of homicides, which has proven to be a reliable means of identifying homicide cases that are not otherwise referred to the DA's office for prosecution.

3. Reports First-responding Agencies (2000 Recommendation)

First-responders (i.e. fire department, other emergency EMT) usually develop important information in evaluating an incident, yet not all prepare reports detailing the information they learn at the scene. First-responders of any type should submit reports to the proper law enforcement agency, in collaboration with any health practitioners to insure compliance with Penal Code section 11160 for reports of suspected domestic violence injuries.

STATUS: This continues to be a problem in Sacramento County. Penal Code section 11160 is not clear as to whether or not first-responders are mandated reporters, and some agencies have chosen to interpret the ambiguity to conclude that they are not covered, due to immunity/liability concerns. The statute has not been amended to deal with this issue. A remedy to this problem lies in either the amendment of the statute, or in agencies electing to interpret the statute to conclude that first-responders are covered.

4. Health Care Providers (2000 Recommendation)

Health care providers have a unique opportunity to identify and intervene with domestic violence. In cases reviewed by the team, only one victim had domestic violence clearly documented in the medical record. None of the victims, perpetrators, or children when seen as patients had formal screening for domestic violence done or documented. Health and Safety Code sections 1233.5 and 1259.5 require clinics and hospitals to have procedures for screening and identifying patients for domestic violence. The team recommends that health care providers make efforts to insure that appropriate screening and referrals in domestic violence cases are made.

STATUS: Accomplished. All local health care providers have procedures and training in place to screen and identify domestic violence victims. The DVDRT has seen evidence it the more recent cases it has reviewed that persons who were seen by health care providers have been screened for domestic violence.

5. Education and Outreach

Domestic violence represents social patterns and ingrained behaviors, not only as to the perpetrators, but also in many instances as to the victims and the agencies in place to deal with the problems. The team believes a need for education and outreach on a variety of fronts to address the issues with domestic violence.

a. A significant number of fatal incidents occur with little or no prior institutional contact reflecting domestic violence. Community education through the faith community, the media, and employers should be disseminated to reach victims, potential victims, and those who may come into contact with victims and perpetrators, with the message that verbal abuse can be a predictor of physical domestic violence, and should not be ignored or minimized.

b. Community education and outreach is needed to (1) de-stigmatize mental health counseling and treatment, and (2) help family members to recognize, rather than minimize or discount, the danger to themselves and others that may arise with a mentally ill family member.

c. All health care providers should be trained that mental health issues may exist when they are presented with a patient (victim or perpetrator) where domestic violence is suspected. Health care providers should foster mental health assessments and intervention where mental health problems are identified.

d. The team recommends that all 911 dispatchers receive additional education on dealing with domestic violence calls, and the dynamics of domestic violence.

e. The team recommends that the appropriate segments of law enforcement be educated on interviewing and photographing child witnesses at domestic violence scenes.

STATUS: Ongoing. Education and training in these areas has been conducted, and continues as an ongoing process.

6. Home Visits (2000 Recommendation)

The DVDRT recommends consideration be given to a pilot program to identify through the mental health system and other appropriate means high risk cases for domestic violence. The pilot program would create a system for monitoring such cases, including home visits, similar to the outreach and intervention system which already exists for dependent adults, or children (child protective services).

STATUS: Recommendation remains open. No agency has developed a pilot program addressing this suggestion.

2001 RECOMMENDATIONS

1. First Responder Mandated Reporting Status (2001 Recommendation)

As noted above, part of the problem associated with first responders (i.e. fire personnel, EMTs, etc.) is the question of their status with respect to the mandatory reporting laws for domestic violence. Health care providers are clearly covered under the mandatory reporting laws, but the status of first responders is not clear. In the absence of immunity coverage, some local agencies are reluctant to adopt policies requiring domestic violence reporting. The team recommends that the legislature amend Penal Code section 11160 to make it clear that first responders are mandated reporters of domestic violence, and thus are covered by the same immunity protections as other health care providers.

STATUS: Unresolved. See status of recommendation 3 for 2000, above.

2. Standard Reporting Form (2001 Recommendation)

Reporting known or suspected domestic violence or abuse is a complicated task. While that fact alone makes the development of a standard form difficult, it also highlights the benefits that a standard form will bring to the field. Sacramento County, in a multi-disciplinary effort that involved law enforcement, health care providers, and dental care providers, developed a single countywide form for reporting domestic violence abuse. The state could profit from a similar effort. Acknowledging that the development of a standard statewide form will be a practical and administrative challenge, the team feels the benefits to be achieved are worth the effort. Accordingly, the team recommends that the appropriate authorities undertake development of a standard form for statewide use in the reporting of domestic violence and abuse.

STATUS: In 2001, legislation enabling the creation of a statewide forensic examination form for domestic violence victims was approved (SB 502). The Office of Criminal Justice Programming underwrote the effort to design the form, and a committee was formed to complete the work. The form will be available by January, 2003. In 2002, additional legislation was approved for the creation of a statewide standardized reporting form for health care providers to use in reporting all forms of abuse, including domestic violence (SB 580). It is anticipated that the work will be completed within the next calendar year, and the form will become available for use in January, 2004.

3. Immigrant Community Recommendations (2001 Recommendation)

As with the state and nation, Sacramento County has a significant population of immigrants from a variety of different cultures. Several of the cases the team reviewed, as well as recent high profile incidents which the team has not yet reviewed, involved immigrants. Domestic Violence is an often-unrecognized problem in these communities, and effective measures to educate and address domestic violence need to be developed. In one instance, the victim was a recent immigrant who had met her husband through an arranged marriage. Once in this country, she was subject to sexual abuse and controlling behavior by her husband before the final fatal incident. While isolation of domestic violence victims is a common phenomenon, it was all the more difficult for a victim without the extended support she might receive in her native community, who also had to cope with unfamiliar institutions and a different language in this country. Likewise, the husband had the difficulty of coping with different role expectations and norms.

Language barriers, cultural differences, and differing views of gender roles which sometimes lead to lack of support in certain segments of the immigrant population, all may combine to inhibit immigrant victims of domestic violence from reporting to health, mental health, social and law enforcement agencies. Additionally, fears of government intervention and/or deportation are real threats to certain immigrants that keep them from requesting any help when domestic violence occurs. These factors create special needs with respect to domestic violence in the immigrant communities that should be addressed:

a. The team recommends that advocates within each immigrant community be identified and educated as to the value our society places on the right of all to be free from domestic violence and the immigration consequences, if any, to a victim of domestic violence. With the proper education and outreach to the community leaders and advocates a step will be taken to break the cultural barriers to effective domestic violence intervention.

b. All law enforcement personnel and first responders should be specially trained to recognize the barriers to effective intervention in the ethnic communities. The domestic violence response teams in the law enforcement agencies should be trained to recognize and be sensitive to the specific cultural taboos in each community and be given the tools to alleviate the shame felt by many victims in the simple act of reporting the violence. To address this issue, there must be a combined effort by government, community leaders and the faith community.

c. Language barriers are a particular problem for the interaction of immigrant communities and the institutions which address domestic violence problems. The team recommends the evaluation of language and translation resources for law enforcement, social service providers, and healthcare providers, with an eye towards a implementing a more practical and helpful system.

STATUS: The Domestic Violence Coordinating Council has adopted as one of its goals for 2002-2003 the identification of community resources in the various immigrant communities, and the identification of language and cultural translation resources. Law enforcement engages in regular diversity training.