SONOMA COUNTY

DEATH REVIEW

TEAM

2001 FINAL REPORT

TEAM MEMBERSHIP

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Domestic Violence Death Review Team
2001 Report
Kathleen D. DeLoe, Chair

In 2001, the Sonoma County Domestic Violence Death Review Team continued the work that commenced with its formation in December 1996. The focus of the Death Review Team is stated in the protocol that guides the review of all deaths in Sonoma County that are related to domestic violence. The purpose of the Death Review Team is to reduce or eliminate incidences of domestic violence by determining the number of domestic violence related deaths in Sonoma County, to review resources, to analyze patterns of abuse, and to explore ways to improve the response to domestic violence in our community. The Death Review Team held regular meetings throughout the year with representatives from the medical community (Kaiser Hospital and the Petaluma Health Clinic), the Department of Health Services, the Sheriff's Department, the YWCA, the Coroner's Bureau, Sonoma County Legal Services Foundation, the Human Services Department and the District Attorney's Office serving on the team.

Sonoma County Sheriff's Department 2001 statistics indicate that domestic violence reports increased by 6% over the previous year and restraining order violations decreased by 5%. The District Attorney's Office 2001 statistics indicate that domestic violence and restraining order cases submitted for review decreased by approximately 20% over the previous year. The filing rate remained the same at approximately 50% of cases submitted.

Only one domestic violence related death occurred in 2001. The case involved a perpetrator who committed suicide (see attached 2001 Case Summary). The Death Review Team actually reviewed several cases in the year 2000, but the deaths occurred in previous years and were presented in the 2000 Death Review Team report. The Death

Review Team agreed to change this practice commencing in 2002, so that the yearly report contains information about the cases reviewed during that year regardless of when the death occurred.

The Death Review Team carried out its work plan outlined in the 2000 report. The Death Review Team continued to meet on a regular basis. The Death Review Team regularly reported its work and findings to the Sonoma County Domestic Violence Action Committee and the Domestic Violence Action Committee Courts and Law Enforcement Subcommittee in a collaborative manner to identify and address domestic violence issues in our communities. In an effort to promote awareness of the effects on children of viewing domestic violence, the Death Review Team was pleased to learn that law enforcement is making efforts to provide advisements to victims and perpetrators regarding the detrimental effects on children of viewing domestic violence.

In an effort to continue the exploration of the effects on children who view domestic violence, an informal study was conducted by the District Attorney's Office of completed misdemeanor domestic violence criminal cases to gather information about how many children are exposed to domestic violence in Sonoma County. The survey captured ages of children, the relationship of the victim and perpetrator, the relationship of the children to the victim and the perpetrator and the level of exposure experienced by the children when the domestic violence incident occurred. The Death Review Team contacted the Sonoma County Probation Department to arrange a presentation and dialogue with the supervising probation officer of the domestic violence unit. The Probation Department certifies the batterer treatment programs and utilizes a psychologist for that purpose. The psychologist, Dr. Mindy Rosenberg, also reviews the programs for content purposes and provides lethality assessment services to the Probation Department. Penal Code Section 1203.097 mandates that the treatment programs include a component concerning effects on children. Since Dr. Rosenberg has extensive training and experience in this regard,

the Death Review Team has invited her to address the Death Review Team regarding the effects on children of domestic violence exposure and to advise the Death Review Team what our community can do to assist children in coping with these situations. The Death Review Team has continued this project into 2002. Other future projects include contacts with other teams in and out of the state to review the type of statistical data other teams gather and to review the approach other jurisdictions use in conducting their reviews.

RECOMMENDATIONS

2001

The members of the Sonoma County Domestic Violence Death Review Team recommend the following:

1. That all law enforcement, prosecution, court personnel ~~and mandated domestic violence~~ reporters continue annual training on domestic violence, including the cycle of violence, risk assessment, and cultural factors ~~(including same sex)~~.
2. That training be provided to the Sonoma County mental health community concerning domestic violence dynamics, including threat assessment issues.
3. That training on the dynamics of domestic violence and mandated reporting law be provided for Sonoma County health care providers.
4. That coordination and communication with the Elder Abuse Prevention Council regarding domestic violence issues involving the elderly continue.

SONOMA COUNTY DEATH REVIEW TEAM

2002 WORK PLAN

The purpose of the Sonoma County Domestic Violence Death Review Team is to evaluate policies and practices used by agencies and individuals in working with the victim an perpetrator in violent relationships. The Team will examine murders, suicides, and accidental deaths caused as a result of domestic violence and determine if other services or better services may have prevented the ultimate death of the individual. The Team will also provide a final report at the end of the year and will make appropriate recommendations aimed at the cessation of murder in domestic violence cases.

The above will be accomplished by:

1. Holding bimonthly meetings to review cases of domestic violence, homicide and suicide to identify areas of need in the system.
2. By attending seminars and training conferences concerning the domestic violence death review process.
3. By reviewing other jurisdictions collection of statistical data and other manners of review in order to better identify gaps in providing services to victims of domestic violence.
4. By making recommendations to the Sonoma County Domestic Violence Action Committee regarding needs in the system, as well as specific institutions or agencies as identified in case reviews.
5. By exploring and promoting awareness of the effects of domestic violence on children through education and training presentations.
6. By expanding membership on the team to include a representative from Sonoma County Probation, Health Services (Mental Health Services) and Human Services (Adult and Aging Division).

2001 Case Summaries

ase 1: Reviewed 7/12/01. Suicide. A 35-year-old Hispanic female report violence by husband on 5/19/01. Perpetrator (husband) was booked into jail just rior to his suiciede. There were no known previous domestic violence violations or arrests for either. There was no known drug or alcohol history. They had n hildren. Her primary language was Spanish. He spoke English. On 5/21/01, he committed suicide by asphyxiation at his workplace. Investigated by Petaluma olice Department.

	1997	1998	1999	2000	2001
Age:					
Average age victim	31 years	25 years	57 years	53 years	38 years
Average age perpetrator	43 years	23 years	65 years	50 years 36 years	
Average age suicide	14 years	3 weeks	None	None	
Age of children killed					
Gender:					
Victim	4 F, 1 M	3 F, 1 M	2 F2	1 F, 1 M	M
Perpetrator	4 M	3 M	M	1 F, 1 M	
Suicide				1 F, 2 M	
Sexual Orientation (S=straight; G=Gay):					S
Victim	4 S, 1 G	3 S (+ 1 infant)	2 S	2 S	
Perpetrator	3 S, 1 G	3 S	2 S	2 S	
Suicide				3 S	
Race*					
Victim	4 C, 1 H	1 B, 3 C	1 H, 1 J	3 C, 2 H	C
Perpetrator	3 C, 1 H	1 AA, 2 C	1 C, 1 H	2 C	
Location of deaths:	5, family home 1, neighbor's home 1, boyfriend's home (In another county)	3, family home 1, ex-husband's home 1, on freeway	3, family home	3, family home 1, in field 1 in homeless shelter	Workplace
Weapons:	4 guns, 1 kitchen knife	Hands, kitchen knife, vase	1 hammer, 1 gun	1 pending, 2 guns, 1overdose, 1CO2	Carbon dioxide

*(AA=African American, B=biracial, C=Caucasian, H=Hispanic, J=Japanese):