# Domestic Violence Homicides in Multnomah County

# 2008 Report and Recommendations

## December 1, 2008

*Multnomah County Domestic Violence Fatality Review Team*

For information on domestic violence or access to resources, or for additional information about the DVFRT process and resources available in Multnomah County, contact:

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# Introduction

What do the following three tragic situations have in common?

- A 24-year-old mother and her children were found dead after police were called when a neighbor reported hearing gunshots. The mother had been shot while on the couch. Her 8-year-old son was shot twice in the head as he lay on a blanket in the living room, his 5-year-old sister stabbed to death in a bedroom. The mother's boyfriend of nearly a year had shot himself in the living room.

- A 47-year old man was killed when he tried to help a stranger. Early one morning a neighbor heard a couple in a nearby apartment fighting. When she yelled at the man to stop beating the woman, the 20-year-old batterer came toward her and threatened her. A man the neighbor had never met before tried to step in and help, but the suspect stabbed him to death in the torso and fled. Friends describe the murdered Good Samaritan as “a kind man always willing to help anyone in trouble.”

- A 54-year-old woman was found stabbed outside her apartment. Both she and neighbors called police that night to complain that her ex-boyfriend was threatening her with a knife. Yet before midnight, in spite of police responding and trying to assist her, she lay dead on the lawn from more than a dozen stab wounds, with a fatal wound to her heart, and the tip of a butcher knife embedded in her skull. By noon the next day, detectives accused her ex-boyfriend, 63, of murder. Their relationship was marked by alcohol, physical violence, harassment and assault arrests, a restraining order, and stalking complaints.

The shared factor is that these homicides occurred in Multnomah County as a result of domestic violence. In 2006, nine people in Multnomah County died in relation to domestic violence, seven homicides and two suicides. In 2007, six people died, five homicides and a related suicide. Through October 2008, five deaths have occurred for the year, four homicides and a related suicide – a total of twenty people dead over three years. In 2007, “Domestic violence accounted for about one-fourth of Portland's killings,” reported Maxine Bernstein in the Oregonian’s annual summary of homicides (January 2008).

We know that every domestic violence situation is unique. Each has different levels of danger, varied involvement with victim support services or the criminal justice system, and different abilities of family, friends or co-workers to intervene. Yet despite these differences, each year deaths results in our community from domestic violence. Every one of these homicides is a reason to keep working to understand how to better prevent domestic violence and its tragic results.

# Domestic Violence Coordination

In 1987, to address the need to improve services for victims of domestic violence and to intervene with perpetrators, Judge Stephen Herrell convened the Family Violence Intervention Steering Committee, now called the Family Violence Coordinating Council. This group has met monthly since then, providing a forum for multi-disciplinary discussion and coordination. The Council advises government policy makers, assists public and private initiatives that address domestic violence, provides training, and identifies and reports on unmet needs, data and trends. The Council currently has 40 member agencies including: Portland Police Bureau; District Attorney’s Office; Multnomah County Court and Sheriff’s Office; Oregon Department of Human Services (DHS) Child Welfare and Self-Sufficiency; and victim services programs.

In 1994 the Multnomah County Board of Commissioners and the Portland City Council identified the reduction of domestic violence as a high priority. The County and City jointly funded a Domestic Violence Coordinator to facilitate coordination of the community's response and to support the Family Violence Coordinating Council. Since then, specialized units have been implemented to provide effective intervention in criminal cases, including in: the Portland Police Bureau (Domestic Violence Reduction Unit), the District Attorney's Office, the Department of Community Justice (Domestic Violence Unit), and the Domestic Violence Court. Victim services have also expanded beyond crisis lines and emergency shelters to include culturally specific services, long-term housing programs, courthouse advocacy, civil legal assistance, and specialized services in the DHS Self-Sufficiency program. Collaborative multi-disciplinary projects include the Domestic Violence Enhanced Response Team (DVERT) that addresses high risk cases, and the Safe Start Program that places domestic violence advocates in a DHS Child Welfare Office. Collaborative projects currently being developed include the Rotary Center for Community Empowerment and the City-County One-Stop Victim Services Center.

Based on this history and expertise in collaboration, and pursuant to ORS 418.714(1), the Family Violence Coordinating Council, in collaboration with the Local Public Safety Coordinating Council for Multnomah County, established the Multnomah County Domestic Violence Fatality Review Team.

## Domestic Violence Fatality Review Team (DVFRT)

Formation of a Domestic Violence Fatality Review Team (DVFRT) is authorized by the Legislature (ORS 418.712 through 418.718), with membership determined for the most part by statute. The Multnomah Domestic Violence Fatality Review Team includes an extensive membership list of local law enforcement, criminal justice, health, human service, and domestic violence agencies. (Please see Appendix B for a complete list of participating organizations.)

The Multnomah County Domestic Violence Fatality Review Team initiated a process to review local domestic violence fatalities in fall of 2006. The purpose of these multidisciplinary reviews is to examine the events leading to a particular domestic violence (DV) fatality, with a goal of learning how a fatality could be prevented in similar cases in the future. Local protocols meet state standards to protect the confidentiality of participants in the reviews. Deep thanks are given to all the family members, friends and co-workers who provided information for the review process.

Multnomah County's Family Violence Coordinating Council and Local Public Safety Coordinating Council collaborate in organizing the fatality review process, which is based on willing participation and open dialogue among members of diverse agencies. Participating agency representatives review the facts of each case, and learn from these tragedies how to improve the local response to domestic violence. The respectful manner of all members participating in this difficult process has facilitated finding opportunities to make progress.

Three reviews have been conducted, in fall of 2006, spring 2007, and fall of 2007. A report was published in December 2007, highlighting 2006 recommendations. The team's time in 2008 has been focused on implementing these recommendations. This 2008 Report combines our recommendations from 2006 to present, and shares progress made toward implementation.

# Recommendations and Results

The team found that recommendations for the three reviews fell within six major areas of need. Areas with significant progress are noted as bullet points under each section. This work, though, is far from finished. The team will continue to learn from future reviews, and seek ways to more fully implement these and future recommendations.

## I. Need for more effective response from people and institutions when abuse was suspected.

Most victims of domestic violence homicide have seen a health care provider in the year prior to their death. Many have talked to family, friends or coworkers. But relatively few victims called police, the Domestic Violence Crisis Line, or other domestic violence services. Therefore, we believe that people outside the DV system often have the best opportunity to intervene. Family members, employers, professional staff, and public safety officials can be more effective in their response to suspected domestic violence if they are more informed about the issues, and the services and resources available to help.

In 2008, Domestic Violence Fatality Review Team members and partners have:

- Formed an Outreach Consortium which has worked together to step up presentations to businesses, civic and faith groups, and government agencies, with a goal of 25 presentations a year.
- Formed a Consortium of victim service agencies who do violence prevention for youth. The group has expanded their curriculum to address violence occurring in the home as well as dating violence, with 35 trainings scheduled in 12 schools through the end of 2008.
- Increased training to employers, human resource staff, and unions on how co-workers can help and what resources are available, with a goal of 25 presentations a year.
- Scheduled training sessions for Family Court and Juvenile Court judges and staff.
- Scheduled a Continuing Legal Education session on DV for attorneys.
- Scheduled on-going, multi-disciplinary training for County Human Services staff and contractors.
- Increased training of professionals in a joint project with the Domestic Violence Coordinator's Office and the Department of County Human Services.

## II. Need to improve communication across systems.

Victims of domestic violence often leave their home county in an attempt to seek safety. Yet it is clear from newspaper accounts that many perpetrators move across county or state lines to continue to harass, stalk or assault their victims. Crimes continue to occur across multiple jurisdictions. A perpetrator may be on probation in one county for a domestic violence crime, yet because of lack of communication, be treated as a new offender in another jurisdiction. Therefore, we believe that good communication across county and state lines, and among the various agencies is essential to reduce domestic violence homicides.

In 2008, Domestic Violence Fatality Review Team members and partners have:

- A policy dialogue is occurring with Clark County officials on communications across state lines, as part of the local Criminal Justice Information System development.

- The Multnomah County District Attorney's Office has arranged for point persons to be identified in the District Attorney's Office in each adjacent county to improve communication on cases.
- Training on Domestic Violence has been expanded in the Portland Police Bureau Advanced Academy. Victim Advocates are participating on the scenario day, improving awareness and teamwork between officers and advocates.
- The Oregon Association of Community Corrections Directors discussed the need for improved communications when moving parole cases involving domestic violence across county or state lines. Members are reviewing their local practices. A training academy session is being planned for parole officers doing domestic violence supervision.

## III. Need to enhance ability to identify and track high-risk cases.

New evidence-based assessment tools have become available in the past five years that help identify high-risk/high-danger domestic violence cases. Increasing use of such a tool to flag perpetrators at high-risk of reoffense, and expanding access to that data to more people who interface with victims, will allow law enforcement officers, court officials and advocates to be more proactive about encouraging a victim to get help, and to respond appropriately to offenders based on the risk they pose.

In 2008, Domestic Violence Fatality Review Team members and partners have:

- The Portland Police Bureau developed, tested and implemented the on-line Family Abuse Supplement report, which is being used by the Domestic Violence Reduction Unit for all new domestic violence reports. The Domestic Violence Reduction Unit will work with other law enforcement jurisdictions to encourage use of the same form.
- Four positions were hired by the Multnomah County Sheriff's Office for a Warrant Strike Team, which can assist the Department of Community Justice Domestic Violence Unit in serving warrants when Probation/Parole Officers are not able to locate offenders, or where offenders are supervised by Corrections Technicians without arrest authority
- The District Attorney's Domestic Violence Unit staff are requesting mental health evaluation and treatment as a condition of probation, if mental health is an issue for domestic violence offenders, including for those on bench probation.

## IV. Need for improved victim access and connection to a domestic violence service.

Many domestic violence homicide victims never access domestic violence services. When victims do try to access services, they often encounter barriers: confusion about available services, a dearth of shelters, a lack of sufficient advocates, and minimal services for people who don't speak English. We believe that improved access to regularly updated information about services that are available will improve the chance for a helpful connection to occur.

This year, Domestic Violence Fatality Review Team members and partners have:

- The Domestic Violence Coordinator's office is planning an upgrade of their website to improve usefulness to victims and their family, friends and co-workers.

- The Gresham Police Department has updated their Crime Victim/Domestic Violence Victim flyer for officers to hand out, available in both English and Spanish.
- The Circuit Court is enhancing the advice that judges share with applicants for restraining orders, to address the need for safety planning and to give referrals.

## V. Need to improve information for professionals to assist them in responding to a specific case.

Health, human service and court professionals have contact with victims and perpetrators of domestic violence, yet are often unaware of the individual's history with domestic violence. These professionals have an opportunity to help not only through improved referral to domestic violence services, but by improving treatment for co-occurring health, mental health and substance abuse disorders. We believe that increasing access to an individual's public record history would enable better treatment of inter-related issues to occur.

In 2008, Domestic Violence Fatality Review Team members and partners have:

- Hired a full-time domestic violence training coordinator with funding from the Department of County Human Services to focus on training for human services professionals and FVCC member agencies.
- Members of DVERT have provided training to 1,161 people on the topics of identifying and responding high risk domestic violence cases and stalking, since 2006.

## VI. Need to identify and fill gaps in existing system that limited ability to respond.

Although there is a lack of adequate amounts of domestic violence services across the spectrum – from information, to shelters, to advocates – sometimes a needed service is not available at all. We believe that filling these gaps in the continuum of services, especially for services targeted to special populations, would help reduce some of the homicides resulting from domestic violence.

In 2008, Domestic Violence Fatality Review Team members and partners have:

- The US Attorney's Office and the Multnomah County Sheriff's Office, along with other public safety and human service partners, have examined issues of prostitution and human trafficking over the past few months, with possible recommendations emerging next year.
- Additional funding from the City of Portland will provide services to women caught up in prostitution.
- Lack of funding has impaired the team's ability to initiate other gap-filling programs.

**Recommended Legislative Initiatives/Changes:**

In addition to the recommendations above for system or response improvements, the Team has identified several priorities for the 2009 Legislative session. These include:

1. Revision of the authorizing domestic violence fatality review legislation so that teams could release findings. These findings would assure that they did not contain information that could identify the victim or perpetrator, and would not place blame on an individual or organization. Currently, teams are only allowed to release recommendations, and without the ability to cite findings, the compelling reason behind the recommendation is lost.
2. Improved statutory authority to access medical records, such as from hospitals, for purposes of death/fatality reviews. Such access would assist the fatality review teams in identifying potential improvements in screening and treatment for victims and perpetrators and improve the likelihood of preventing deaths.
3. Funding to support local domestic violence fatality review teams throughout the state, and possibly a regional (Tri-County) team. Currently, only Multnomah County has had the capacity to convene a fatality review team and to review cases, as such reviews are time-consuming and require a significant level of staff support.
4. Advocating for action related to specific recommendations made in this report, including funding: to educate youth about how to recognize and respond to domestic violence, to assure supervision for misdemeanor person crime offenders, and to increase resources so that victim service agencies have the capacity to respond to referrals from criminal justice agencies. Other State actions could include: the development of a searchable, publicly available Restraining Order database and resources to limit gun access to convicted domestic violence offenders.

**Appendix A**

# Compiled DVFR Recommendations – 2006-2008

***Approved 10/2/08***

The Multnomah County Domestic Violence Fatality Review Team has completed three reviews of cases where a death resulted from domestic violence. The following list compiles the Team's recommendations for action to improve our community's response to domestic violence and to reduce the number of fatalities related to domestic violence.

## I. Need for More Effective Response from People and Institutions when Abuse was Suspected

### A. Educate the general public to recognize & respond to domestic violence.

A1. Increase efforts to provide information to community groups, businesses, and others through the Family Violence Coordinating Council Speakers' Bureau and victim advocacy organizations. Include information on risk factors that indicate a high potential for lethal violence. Include actions that victims, family, friends or co-workers can take, and resources available.

A2. Release public service announcements on dangers of domestic violence.

### B. Educate people at their workplace to recognize & respond to domestic violence.

B1. Encourage domestic violence training at the workplace, specifically about how to ask if a co-worker needs help, what resources are available for victims, including the crisis line, and how to develop a safety plan, as well as the new DV law for employers.

### C. Educate youth about how to recognize & respond to violence prevention.

C1. Develop and implement an inter-personal violence education and prevention curriculum for youth in schools. Address issues that affect youth directly: bullying, controlling or jealous behavior, and coercive versus equal relationships and safety planning. Expand to include violence in the home.

C2. Train professionals who work with youth about prevention of dating and relationship violence, beginning in middle school. Develop a process for referring youth who show signs of abuse to appropriate resources.

C3. Work with School Districts to expand their curriculum on bullying to cover domestic violence.

### D. Increase knowledge in Justice System about domestic violence, services and resources.

D1. Provide education, technical assistance and training for all in the justice system who may have contact with victims of domestic violence, so that professionals have the knowledge and resources to link victims with victim services agencies or other appropriate resources.

> D1a. Assure that Court judicial officers, referees and staff have training on domestic violence, and regularly updated information on services available for DV victims and where to make referrals.
>
> D1b. Assure that Juvenile Court community also received training on DV issues pertinent to youth.

D2. Offer Continuing Legal Education (CLE) training for civil and criminal attorneys so that more attorneys understand: the dynamics of domestic violence-; the basics of domestic violence intervention and prosecution; how to identify high risk DV offenders; the link between drug use, prostitution and domestic violence; and resources available for clients and victims.

**E. Increase the capacity of health and human service staff to recognize and respond to victims of domestic violence.**

E1. Improve the ability of the medical community to assess and link potential domestic violence victims with services while still in the medical setting.

E1a. Raise awareness of need for a systematic response by hospitals.

E2. Train health care workers on predictors of DV homicide/fatalities, and strategies to reduce the risk of a fatal outcome.

E3. Increase training for Mental Health and Addictions providers on their awareness of DV, how the DV system works, and who to call for appropriate intervention.

## II. NEED TO IMPROVE COMMUNICATION ACROSS SYSTEMS

**F. Increase communication within and between Law Enforcement and Criminal Justice Systems.**

F1. Improve inter-county and inter-state communication on DV cases.

F1a. Initiate a policy dialogue with Clark County officials on the importance of/ways to improve communication across state lines.

F1b. Raise the issue of inter-state communications with Oregon's Interstate Compact Office.

F1c. Develop interagency contacts & communication strategies to help facilitate the sharing of documents and other information between jurisdictions.

F2. Train District Attorney staff on importance of communicating with other jurisdictions about cross-jurisdictional histories of DV in relationships.

F3. Train law enforcement agencies about the requirements for mandatory reporting to Child Welfare, including when children witness DV.

F4. Improve DV offender supervision statewide by asking the Oregon Association of Community Corrections Directors (AOCCD) to create a workgroup to develop statewide policy on training, risk assessment and communication; include victim advocates on this workgroup.

**G. Improve or increase communication between Advocates and the Criminal Justice system.**

G1. Improve communication, cooperation and cross-training between victim advocates and the criminal justice system

G1a. Increase resources so that victim services agencies have the capacity to respond to referrals from criminal justice agencies.

**H. Increase communication between Health Care and Domestic Violence services.**

H1. Reinvigorate Health Care Systems United to examine how health systems can better help DV victims.

H2. Improve connections with hospitals to do cross-referrals for victims who could benefit from legal representation or access other services.

### I. Improve access to medical records to better support the DV Fatality Review process

I1. Clarify HIPAA (Health Insurance Portability and Accountability Act, Standards for Privacy of Individually Identifiable Health Information) requirements regarding providing access to medical records for DVFR reviews.

## III. Need to Enhance Ability to Identify and Track High-Risk Cases

### J. Improve ability of professionals to recognize and track high-risk domestic violence perpetrators.

J1. Continue to develop the Family Abuse Supplement which captures a computerized recidivism score.

J1a. Expand use of this tool to other jurisdictions.

J3. Create the ability to flag a high-risk perpetrator that follows the perpetrator from system to system, so that when a restraining order is requested, researched or issued, this information appears. Provide information to law enforcement officers, the Sheriff's office, Court officers/staff, and advocates so all are informed of risks, and able to help the victim understand the need for a safety plan.

J4. Improve access to clear, succinct records for high-risk DV perpetrators for judges, advocates and others. Develop means to gather information from multiple local, regional and state agencies in an accessible format. Clarify access restrictions. Clarify how much may be shared with a person requesting a Restraining Order.

J5. Identify the highest risk DV offenders for intervention, using factors associated with DV recidivism, in order to most effectively target limited police resources, and develop a plan for how to address this.

J6. Fund a Regional Domestic Violence Reduction Team (R-DVERT) program to develop protocols and appropriate inter-agency agreements to assure seamless enforcement of laws and other batterer accountability strategies across county and state lines.

J7. Support aggressive warrant enforcement for priority high-risk cases, and track results of this effort.

### K. Improve effective treatment of high-risk DV perpetrators.

K1. Encourage judges to request mental health evaluation and treatment as a condition of probation if mental health is an issue, especially for those on bench probation.

## IV. Need for Improved Victim Access and connection to a Domestic Violence Service

### L. Improve access to up-to-date information for DV victims.

L1. Improve electronic access to information for DV victims. Consider:

a. a website like the "System of Care" website for elders;
b. linking with other victim-based websites (child abuse, elder abuse)
c. collaborating with 211 Info, which keeps a current data base already;
d. link with the new "One-Stop" center being developed.

### M. Communicate options to all domestic violence victims.

M1.Develop a flyer or card to give information and referrals to a domestic violence victim when police respond to a call, even if there is no arrest or follow-up.

M2. Develop gender-specific materials for men who are victims of domestic violence, including attention to cultural differences and barriers.

M3. Provide Restraining Order petitioners with clear information on the limitations of a RO and the need for a safety plan.

M4. Review Restraining Order judicial process with Judges to examine content of speeches to those seeking restraining orders to: address the need for safety planning, share personal concern over safety, and provide referrals.

M5. Use the advocate call-back process to follow up on whether the RO was issued, re-visit petitioner's safety plan and offer connection to further resources.

## V. Need to Improve Information for Professionals to Assist them in Responding to a Specific Case

### N. Improve ability of professionals to obtain information about prior DV assaults to allow them to more effectively support the victim.

N1. Increase the capacity of hospital staff to respond effectively on-site to victims of domestic violence.

> O1a. Improve health care and human service systems' ability to recognize and serve DV victims. Create access for providers to an individual's DV history; strengthen understanding of what this means.

N2. Develop a searchable Restraining Order data base, in multiple county locations.

### O. Improve professional knowledge about impact of specific factors in DV cases, and how to effectively respond.

O1. Research which cases are not appropriate for bench probation versus Department of Community Justice probation; assess the comparative recidivism of the two types of probation.

O2. Improve mental health, addictions and physical health treatment outcomes for an individual who is also experiencing domestic violence, through a holistic approach.

O3. Research and develop information and training on the relationship between traumatic brain injury and impact on perpetrator and victim.

## VI. Need to Identify and Fill Gaps in Existing System that Limited Ability to Respond

### P. Improve identification and follow-up for suspected victims.

P1. Conduct in-home follow-up for people released from jail who are suspected of being domestic violence victims, similar to the Adapt Nurse program that visits pregnant inmates after release.

P2. Develop a new way to provide prevention and intervention around domestic violence for victims charged with misdemeanors dealt with by the Courts, especially prostitution.

### Q. Remove barriers for victims to seek help.

Q1 Develop a pet care program. Advertise existing services, so that pet care is available to assist victims in leaving dangerous situations.

### R. Reduce perpetrators' access to weapons.

R1. Limit gun access to convicted domestic violence offenders and restraining order respondents by better utilizing existing state and federal laws. Reduce availability of handguns in DV households, and thus reduce the likelihood that the gun will be used for a homicide.

**Appendix B**

## Domestic Violence Fatality Review Team

## Participating Organizations, 2008

**Domestic Violence Services**
Catholic Charities' El Programa Hispano, Project UNICA
Choices DVIP
Desarrollo Integral de la Familia
Multnomah County Domestic Violence Coordinator' Office
Multnomah County Family Violence Coordinating Council (FVCC)
Raphael House of Portland
Volunteers of America, Home Free (VOA)

**Health and Human Services**
Health Providers
Multnomah County Department of County Human Services (DCHS)
Multnomah County Mental Health and Addictions Services Division (MHASD)
Multnomah County Health Department
Oregon Department of Human Services (DHS)

**Law Enforcement**
Gresham Police Department (GPD)
Portland Police Bureau (PPB)
Multnomah County Sheriff Office (MCSO)

**Legal & Courts**
Circuit Court
Metropolitan Public Defenders
Multnomah County Attorney
Multnomah County District Attorney's Office
Multnomah County Legal Aid
Oregon State Medical Examiner

**Probation & Parole**
Department of Community Justice (DCJ)

**Public Safety**
Local Public Safety Coordinating Council (LPSCC)