Deaths Resulting from Domestic Violence in Alameda County in 1996 and 1997

Report of the Death Review Team

July 2000

1. Introduction

a. Purpose of this report

This report is both the result of a long process, accomplished by volunteers and donated employee time (from public and private agencies alike), and the beginning of a formalized, on-going review process in Alameda County, also maintained by volunteer- and donated- employee efforts. The information presented in this report has never been tracked by any agency before.

The Death Review Team is a subcommittee of the Family Violence Council, which itself is a committee of the Consolidated Courts in Alameda County.

This report summarizes the information collected for the deaths in Alameda County during the years 1996 and 1997 which can be entirely attributed to domestic violence, or which domestic violence played a significant contributing factor to the fatality. The information comes from many sources and through the cooperation of many agencies, and represents a true collaboration between the public and private sectors.

b. The Death Review Team

Purpose of the Team

The Death Review Team is a multi-disciplinary, multi-agency team established by the Family Violence Council of the Superior Court whose goal is to identify and review deaths related to domestic violence. The goal of the Death Review Team is to improve the systemic response to domestic violence rather than to evaluate individual performance or peer review. The purpose of the DRT is:

1. To gather information in order to develop recommendations for agency policies, and to provide information to the public with the purpose of reducing the incidence of domestic violence; and
2. To assist coordination between various agencies involved in domestic violence cases, including providing a safe, confidential forum for inter-agency discussion.

Participants and Process

The DRT benefits from the views of a diversity of people. The membership of the DRT is comprised of members who meet the criteria of the CA. Penal Code 11163.3 (d) (See Appendix 3). The following is a list of the individuals and agency representatives who currently review data on a monthly basis.

DRT MEMBERS for Year 2000

DRT MEMBERS for Year 2000	
Family Violence Council	Mary Duryee, Ph.D., Chairperson
Consolidated Courts Family Court Services, Family Law Facilitators, Probate Investigaors Drug Court Services	 Ruthanne Allen, Ph.D. Deborah Chase, Attorney Tom Surh, Attorney Pam Williams Carol Lee, Ph.D.
Probation Department	Arthur Pigg
Family Law Attorney/ Gay and Lesbian families	Liz Hendrickson, Attorney at Law
Social Services, Child Death Review Team Children and Family Services Children and Family Services	 Elsie Rutland, Janette Bormann Laura Andrews Esther Martino
Public Health Maternal Child and Adolescent Health Emergency Medical Services	 Jogi Khanna, M.D. Alameda County Pat Bennett, Emergency Services
Highland Hospital, Emergency Medicine	Hillary Larkin, Phys. Asst. Certified,
Kaiser Hosptials, Emergency Medicine	Suzanne Summer, M.D.
St. Rose Hospital	
Summit Hospital	
Alameda Hospital	
Alta Bates Hosptial, Emergency Medicine	Monica Rosenthal, M.D.
Shelters	Kat Morgan
Law Enforcement Coroner's Office, Sheriff's Department Forensic Pathologist	 Al Guzman, Union City P.D. Lt. Pat Adams Sharon Van Meter, M.D. Mayse Taylor, Hayward P.D.
D.A.'s Office	Paul Pinney, South County D.V.

DRT MEMBERS for Year 2000	
D.A.'s Office	Eileen McAndrew, Stalking Unit Dan Burke
Community Agency / Batterer's Treatment	Carol Kennedy, Second Chance

At monthly meetings the DRT reviews records from various agencies: criminal records, police reports, medical records, coroner's reports. Alameda's DRT made a decision early in its process to attempt to find every death associated with domestic violence during a calendar year. The Coroner's Office provides the initial records. All coroners' reports of traumatic and suspicious deaths are reviewed for a given year, and those in which domestic violence was possible or likely are listed for further review. This is a laborious process: upwards of 3000 reports are reviewed which results in a list of cases categorized as "confirmed", "suspected," or " to be investigated." [2] This is the first stage of reviewing fatalities. Most of the cases are picked up through this avenue though a few are added because of information from newspaper articles or reports of concerned community members.

The "suspected" and "to be investigated" cases remain on the list or are dropped depending on information from other sources because we determined the case was not domestic violence related. Information about all cases is augmented by checking police reports, medical records around the County, checking court records for the presence of Temporary Restraining Orders (TRO's), dissolution filings, Domestic Violence Prevention Act (DVPA) filings, Family Court Services records, and the like. All of this second stage review is accomplished by members of the DRT who take the case information back to the databases within their own agencies, and review their files for relevant information.
In short, there is no central location where all this information is kept. It must be collected piece by piece.

c. History

Given the highly sensitive nature of the material gathered and reviewed, and given the volatile discussion that sometimes surrounds the topic of domestic violence, developing the collaboration, initially, was a lengthy and complicated process. Alameda's efforts to establish a DRT, which

[2] The 3000 records reviewed are a subset of the total deaths Alameda County. For 1996 there were 9,880 deaths; for 1997 there were 9,566 deaths.

began five years ago, has run parallel to, and slightly preceded similar processes in other counties around the State, which culminated in supporting legislation (Penal Code 11163.5). (Some members of this committee, in fact, participated in early meetings with the Attorney General's office to discuss statewide coordination of the collection of this data, and providing support to counties to start local DRT's.)

Early in our discussions we decided that Alameda's DRT would focus on improving system response rather than acting as an investigative body or as a citizen review body. Unlike the Child Death Review Team, which may reopen an investigation on a child's death, this Team does not interfere with or supplant law enforcement investigation. The DRT process intentionally trails temporally behind the official processes of investigation.

A significant part of the historical effort was spent finding out which agencies collected which pieces of information. Parallel to that discussion was an equally complex process of deciding which pieces of information would be most important and informative. Finally, a comprehensive definition of domestic violence was developed which is more inclusive than the one defined by the Penal Code and follows the Family Codes more closely because our purpose is to provide information with the aim of preventing fatality. In that context, being able to compare statistics to those maintained by law enforcement is less important that capturing useful information, which meant being more inclusive. (Specifically, we have included those related in the same household—adult sibling violence, and elder abuse).

Our next efforts focused on finding ways to develop a cooperative process of sharing confidential information. This required thinking through procedures and policies that protected both the individuals involved and the responsibilities of the agencies involved for protecting information. The Court Executive office was instrumental in obtaining clearance for DRT members to review criminal records (rap sheets) which in Alameda is stored in a data system called CORPUS. Legislation (Penal Code 11163.5 et seq.) was passed midpoint in the development of the Alameda DRT which provided additional protection to agencies and individuals who share confidential information, and this protection was made even more explicit in amendments passed this last term, going into effect January, 2000.

This is a process in continuing development. When we started gathering information in 1996, we did so with the idea that our process would not be remotely ideal, and that we would learn as we proceeded. We expanded the questions we asked in 1997 because of what we found in the 1996 data. We found that the way we labeled the cases became more complex: for example, it was clear that listing the fatality merely as a "homicide" did not distinguish between those homicides

in which a batterer killed a partner from those homicides in which the police, or someone else, killed a perpetrator of domestic violence in self-defense, and another category was added. This year (2000) the State has promulgated a list of categories dovetailing with the categories we had already developed. There are differences, however, which has necessitated further clarification in the way that the data is presented.

2. Domestic Violence Related Deaths: Summary of The Data

a. Explanation of the Data Categories

Cases are listed in the following categories. In the first column the categories developed by the Alameda DRT are described; the second column show the corresponding categories developed by the Attorney General's Office for California:

Alameda Data Categories	California State Data Categories (P.C. 11163.6)
A. Homicide Directly or indirectly perpetrated by an intimate/partner/family member	**A. Homicide Victim is D.V. Victim** Homicide committed by a current or former spouse, fiancee or dating partner **D. Homicide victim is D.V. perpetrator** **I. Homicide victim is homicide perpetrator of a family member other than intimate partner**
B. Suicide Closely related to a D.V. event	**B. Suicide victim is also D.V. victim** **C. Suicide victim is homicide perpetrator**
C. Bystander	**E. Child of homicide victim or perpetrator** **F. Homicide victim was next partner, spouse, fiance or dating partner** **G. Homicide victim was law enforcement officer or emergency personnel.** **H. Homicide victim was a family member,** other than identified above.
D. D.V. was contributing factor, But not sole cause	

Other information gathered by the DRT included:

1. Age of the victim
2. Gender of the victim
3. Race of the victim (Caucasian, African American, Hispanic, Asian,Filipino)
4. Police jurisdiction in which the death took place
5. Method of the death (e.g., gun, assault, asphyxiation, overdose, hanging, etc.)
6. Location of the death (e.g., home, work, in public place, etc.)
7. Whether there were child witnesses
8. Prior domestic violence events (police, dissolution filings; hospital visits)
9. Whether there was a TRO protecting the victim
10. A description of the circumstances.

b. Definitions.

The DRT developed the following definition of domestic violence, and of the persons to whom it applies:

1. **Domestic violence is defined as one or more of the following acts by a family or household member:**
    a. Intentionally or recklessly causing or attempting to cause bodily injury to a family member or household member;
    b. Intentionally or recklessly causing or attempting to cause sexual assault to a family member or household member;
    c. Intentionally or recklessly causing or attempting to cause a family member or household member to have a reasonable fear of imminent, serious, bodily injury to that family or household member.
2. **Family member of household member is defined as adults or minors who are one of the following:**
    a. A spouse or former spouse
    b. A person who regularly lives or used to live in the household;
    c. A person who is dating or used to date the alleged abuser;
    d. A person who is having or used to have a sexual relationship with the alleged abuser;
    e. A person who is related by blood or adoption;
    f. A person who has been or currently is related by marriage;
    g. A person who has a child with the alleged abuser;
    h. A child of a party or a child who is the subject of an action under the Uniform Parentage Act, where the presumption applies that the male parent is the father of the child to be protected.

c. Type of data collected

All of the information in this report was obtained through the records of agencies who had contact with these individuals and families. Some Death Review Teams interview family members and others who were directly involved in a particularly instance. We have not yet developed a mechanism for building this into our process, but may in the future.

d. Problems in Interpretation & Limits of the Data

The most significant limitation of these data is that we have no way of really knowing whether we have captured all the fatalities related to domestic violence. If there is a trend to the error in our data, it would be in the direction of under-reporting the fatalities, because of our method of finding cases. Since we reviewed the Coroner's fatality reports of traumatic and suspicious deaths only, there may have been deaths that were domestic violence related but which appeared to be another kind of injury or illness. In those instances a death certificate was filled out by a family physician in such a way that it did not trigger a Coroner's report or when other factors mask the presence of domestic violence. Finally, at the moment we do not have the capability of getting information from other counties when cases have multiple county contacts with law enforcement, medical facilities, etc.

While we have made attempts to determine the presence of alcohol or drugs in the instances of fatalities, we are not confident enough in our ability to screen all cases for this variable and therefore have not included that as part of our data.

When we were unable to get a piece of information we indicated that through the 'unknown' category. There are several types of information which were difficult to get. We were not always able to confirm the presence or absence of prior history of domestic violence through contacts with public or private agencies. The most difficult type of information to track down was hospital records which reflect use of emergency facilities. Temporary restraining orders were also difficult to track because court records do not include the protected person's birth date, which means that it is often impossible to tell whether we have the correct 'Mary Jones.' Likewise, the coroner's reports do not include the birth dates of suspects or perpetrators.

3. The Data: Analysis and Recommendations

The full list of the fatalities is presented in Table 1 (1996 Summary), Table 2 (1997 Summary) and Table 3 (Combined Summary). In those Tables, the data are organized so that it is possible to distinguish the cases by the Alameda DRT data categories from the categories developed by the State of California. What follows here is a summary of the data only by Alameda DRT data categories. Each section includes an analysis of the data and Alameda DRT recommendations flowing from the analysis.

a. Demographic information for fatalities:

1996 & 1997	Average age	Female/Male	Race	DRT Fatalities		Alameda*
N = 60	36 Years [Range: Fetus - 75yrs]	Female 47% (28) Male 53% (32)	African/A	2	35%	19%
			Asian/Pacl	5	8%	19%
			Caucasian	21	35%	46%
			Hispanic	12	20%	18%
			Unknown	1	2%	

*(Source U.S. Census 1997. Total population: 1,371,067):

b. Gender of the victim. The demographic numbers warrant careful scrutiny, particularly in the area of the gender of the victim. The national data about battering show that it is a "gendered" phenomenon: women are overwhelmingly the victims and men overwhelmingly the batterers.[2] The number of male fatalities in this list and the balance of male to female victims was a surprise; we did not expect to find more male fatalities than female. A closer look at these data show some distinct trends, which become apparent when the fatalities are divided according to category, and which have important ramifications for both services and public policies:

When the ***homicide victim was also the victim of domestic violence***, the percentages

[2] The *Bureau of Justice Factbook* reports that 85% of domestic violence victims are women. Greenfield, L. *Violence by intimates: Analysis of data on crimes by current or former spouses, boyfriends, and girlfriends.* Washington, D.C.: U.S. Department of Justice, March 1998.

change dramatically: ***85% of these fatalities were female*** (23 victims for the 2 years); The female victims all appear to fall into the expected scenario: a partner, ex-partner, or intimate kills her. Only one of the perpetrators in this category of homicides was female. Of the four male victims who make up the 15% male victims, 3 were men killed by their male partners or male roommates, and one was a male victim of a female partner. In the later situation the homicide was not self-defense; we determined that this woman had a prior history of violence (charges for assault) similar to many of the male perpetrators.

When the ***homicide victim was also the perpetrator of domestic violence, 100% of the victims were male*** (3 victims in 2 years). These victims were killed by female partners and ex-partners, and there was a confirmed pattern of domestic violence in the relationship in which the male had been the batterer.

100% of the suicide victims were male, (17 in 2 years), and all of the suicide victims had also been perpetrators of domestic violence prior to the event. A number of the fatal events involved more than one fatality, often a homicide/suicide combination, and sometimes including a third bystander fatality: there were seven such events in two years. Several of the suicides had been preceded by attempted homicides: the intended homicide victims were shot but did not die.

Of the **8 bystander fatalities,** ***6 victims were children, 10% of the overall fatalities for two years.*** Three of these were fetuses who had achieved viability, whose mothers did not die; the oldest child was 6, killed as a hostage; and the two remaining were killed when their mothers were killed.

50% of the bystanders fatalities were male, 50% were female, (8 total in 2 years). One of the victims was another family member; (a brother); one was a good Samaritan attempting to protect the other homicide victim.

FATALITIES FOR 1996 & 1997

FATALITY WAS:	MALE	FEMALE
D.V. Victim	4*	23
Perpetrator of D.V.	3**	0
Suicide victim	17	0
Bystander	4	4
TOTAL	28	27

* 3 of these males were killed by male boyfriends or roommates; one was killed by a female partner.

** These three males were killed by female partners or ex-partners.

*** 6 of these bystanders were minors: 3 fetuses; a 7 month-old; a 1.5 year old; and a 6 year old.

From these data, women and men die in nearly equal numbers. ***However, men and women died under very different circumstances, and this has policy and service implications. It is also clear that children are also victims at a high frequency.***

These data suggest that clinicians and other service providers pay particular attention to the presence of depression and other psychiatric disorders associated with suicide in known or suspected batterers. We suspect that depression adds substantially to the risk of fatality in domestic violence situations. This recommendation would affect hospital and mental health agency screening protocols; police intervention at the scene of a domestic violence call; family court services recommendations in DVPA and dissolution action cases. These data also suggest that those service providers who have contact with children, and become aware of a pattern of domestic violence, should be aware that the risk for harm is not only for the intimate, but for the children as well.

c. Race of the victim. It is not possible to draw any inference from our data about the racial background of the victims because we do not have enough information. A variable implicated in the increased risk for domestic violence is poverty and low-economic status, and unemployment, and these are confounding variables with that of race.

> "Although domestic violence occurs in all socioeconomic groups, there are close correlations between poverty and domestic violence. Domestic violence can cause

families to become poor, and make it harder for them to escape poverty... the correlation also runs in the other directions: Poverty can make women and children more vulnerable to domestic violence, in that parents with less money are more likely to be economically dependent on violent partners, and less able to relocate, hire lawyers, or obtain access to health care, counseling, and other services."[3]

We have not been able to obtain information about socio-economic status of these victims, which limits the ability to analyze this.

d. Age of the victim. The age of the victims ranged from viable fetuses to 75 years. We did not discern a pattern of distribution for age among the categories.

The number of children involved in fatal incidents, particular fetuses, suggested that pregnancy is an added risk factor in situations where there is domestic violence and that the presence of violence between adults in a household spills over onto children directly.[4] It also affects children who witness he violence but are not the direct objects of the violence. This circumstance is taken up in a later section.

e. Characteristics of the Fatalities

1996 & 1997 Totals

N=	Method			Location		
60	Gun	38	63%	Home	43	72%
	Knife	6	10%	Work	6	10%
	Assault	7	12%	Public	7	12%
	Asphyxia	1	2%	Hotel	2	3%
	Overdose	3	5%	Unknown	2	3%
	Hanging	1	2%			
	Other	3	5%			

[3] Matthews, M. (1999) The Impact of Federal and State Laws on Children Exposed to Domestic Violence, In *The Future of Children: Domestic Violence and Children*, The David and Lucile Packard Foundation, V.9, N.3. See also Lyon, E. Poverty, welfare and battered women: What does the research tell us? Harrisburg, PA: National Resource Center on Domestic Violence, December 1997. (800) 537 2238.

[4] Gazmararian, J.A., Lazorick, S., Spitz, A.M., et.al Prevalence of violence against pregnant women. *Journal of the American Medical Association* (1996) 275:1915-20.

N=	Method			Location		
	Unknown	1	2%			

Guns are by far the most common method of fatality across all types of deaths associated with domestic violence. Over these two years, 100% of suicides and 60% to 75% (1996 and 1997 respectively) were the result of guns.

A simple explanation for this is the greater likelihood that the use of a gun in a single, impulsive moment will result in injury or death. Other methods require more concerted, sustained effort (with the exception of the use of an automobile, which occurred in two of the fatalities). Whatever the reason, the presence of a gun in a home seems to increase the risk of fatality. These data support the recent change in the code which requires those against whom a TRO has been issued to turn over their guns to a law enforcement agency.

Knives are the second most likely method. In these two years knives were only used against the primary target of the domestic violence; never in suicides and not against bystanders.

The overwhelming majority of the deaths occurred at home (72%). Suicide-homicide events were more likely to occur at home or in a 'private location' such as a hotel room. Predictably, a higher percentage of bystander fatalities occurred in the workplace; of the four that did not, three were children.

f. Previous Contacts with "the system": police contact and TRO's

1996 & 1997		DV history?	TRO?
N = 60	Yes	36	16
	No	4	17
	Unknown	19	27
	Stalking	1	0

As indicated, there were a large number of cases in which we were unable to determine whether there had been a domestic violence history which lead to a contact with an agency, or whether a TRO had been issued for a victim, or against the suspect or perpetrator. If the 'unknowns' are set aside for a moment, the remainder show a disparity between the confirmed presence of domestic violence and the confirmed presence or absence of a protective order. This may in part be statistical artifact, since the two are related. 100% of those with a TRO are, by definition, confirmed as having a history of domestic violence. The reverse is not true: there were seven instances (of 60) in which there was a confirmed history of domestic violence contact and a ***confirmed absence*** of a protective order. So the 'yes' column for D.V. history will always be higher that the 'yes' column for TRO.

g. Presence of Child Witnesses at the Scene

1996 & 1997	Child witness/Child at scene		
N = 60	Yes	16	26.6%
	Possible	6	10.0%
	No	11	18.3%
	Unknown	27	45.0%

One of the changes in gathering information we began to make over the course of these two years was to look more carefully at who else was present when a fatality occurred, particularly children. This lead us to wonder as well what happened to them after the event. We found it difficult to find information on both questions.

We also found that Alameda County does not have a uniform protocol or referral mechanism for deciding placement of children, either immediately or long-term, after such an incident, nor are there referrals for crisis intervention or follow-up therapy (unless the children have been identified by Victim Witness in some manner). As a result this issue was referred to the Family Violence Council, which in turn referred it to the District Attorney's office, where it is currently being studied.

4. SUMMARY and RECOMMENDATIONS

a. Data Collection:

1. **Concern about Interference with investigative processes.** A great deal of focus on the part of the DRT was directed toward addressing concerns about whether the work of the DRT would be disruptive to on-going investigative processes of the law enforcement agencies involved. To date, we encountered no problems in this area.

2. **Improving quality of the data.** The Team acknowledges that there will always be a certain number of cases for which it is impossible to determine what happened. However, there are still large gaps in our ability to get information.

a. We have made great progress in **getting hospital records**, particularly from the Kaiser system. Nevertheless, there are still a significant number of hospitals in the county which do not contribute information to the DRT.

Recommendation: each hospital in Alameda County should designate a contact person with access to hospital records to provide information to the DRT.

b. The information in **police reports** is critical to the DRT, and obtaining them from all the various jurisdictions has proven difficult, cumbersome, and in some instances, impossible.

Recommendation: a standard means of obtaining police reports for every identified case should be established for the DRT. This standard means might be through the D.A's office, or through a representative from law enforcement.

c. Being able to **correctly identify** individuals has been difficult or impossible when birth dates are not available. For example, when trying to determine whether a TRO has been issued in a particular family situation, the lack of a birth date for the protected person on the TRO form has meant that we had difficulty matching the names on TRO's with the names of the victim. The lack of a birth date for the suspect on Coroner's reports has made it difficult to match with names on TRO's. This latter may be remedied by our ability to obtain police reports that are much more likely to contain this information. The task of being able to put together

information from a variety of sources – police reports, court records, medical records – requires that more information than just a name be used in each instance. Adding a birth date to each name would greatly enhance our ability to put data together. This tracking difficulty is a larger problem than can be answered within Alameda County.

Recommendation: Refer this problem to the Attorney General's office for review and recommendation.

d. Alameda County DRT found that adding a category which counted those cases in which domestic violence was a contributing factor but not primary cause of a fatality to be valuable. This is not currently a statewide data element. Additionally, the state fatality category that described a suicide following a homicide is more restrictive than the category used in Alameda. We had a number of situations in which a suicide followed at attempted (but unsuccessful) homicide.

Recommendation: Refer to the Attorney General's office to consider expanding the definitions for data categories regarding domestic violence related suicides, and deaths for which a significant contributing factor was domestic violence.

e. Alameda County DRT should **track the outcome for children who were present** or witnesses to a homicide related to domestic violence.

Recommendation: Receive a police report on every case. Make a request to all law enforcement jurisdictions that police reports include as a matter of standard practice, a notation about the presence of children at a homicide scene, including who they are, and how they are related to the victim and/or perpetrator.

f. Alameda County DRT should look into the possibility **of receiving information from families directly**. Of particular interest is data which concerns precipitants to lethal domestic violence which would increase our ability to ascertain risk factors – stress from other sources (such as job loss), drug and alcohol use, use of threats, etc.

g. ***Recommendation***: *Alameda County DRT or the Family Violence Council should pursue* ***establishing a permanent, on-going analysis of domestic violence fatalities*** *including the expertise of a crime analyst, and a central repository for data, which would be accessible to relevant and concerned agencies. Two agencies who might be candidates to host this project are the Sheriff's Department or the Department of Public Health.*

b. Primary prevention of fatalities associated with domestic violence:

3. ***Recommendation:*** *Relevant Alameda County agencies should develop a* ***lethality screening protocol*** *to be used by first response professionals (law enforcement, medical personnel). We believe this would enhance the system response in Alameda.*

A screening protocol that is uniform around the county would allow people from various agencies to communicate with one another about the level of risk within a particular situation. For example, a hospital social worker referring someone to a shelter would be able to communicate the current assessed level of lethality risk; police reports could communicate the level of risk to courts; hospital staff to police, police to mental health professionals considering hospitalization, etc.

Given the high number of suicide-homicide events, we suggest that a simple question which probes for **suicidality on the part of the batterer** be part of such a screening protocol (such as "Have you ever heard the perpetrator say he was going to kill himself or you?" Another question might be "does the perpetrator own a gun?")

Police and mental health professionals in the county should consider the level of suicidality in a batterer or perpetrator when considering 5150'ing an individual, or when considering extending a 72-hour hold.

4. ***Recommendation:*** *Given the high level of risk when* ***guns*** *are present in the home, we urge that courts who issue TROs in domestic violence cases enforce the turning over of such weapons when a TRO is issued.*

5. ***Recommendation:*** *we recommend that Alameda County court* ***review the current bail schedule*** *in comparison with other counties, and develop a schedule for setting bail in felony domestic violence cases. The bail schedule should be tied to a lethality screening*

protocol, mentioned above.

6. ***Recommendation:*** *Alameda County Family Violence Council sponsor the* ***development of a protocol for immediate intervention with children*** *at the scene of a homicide which would include the provision of follow-up services*, and a review of the long-term placement decision.

c. Secondary Prevention Recommendations:

7. ***Recommendation:*** *Alameda Family Violence Council should support public education that tells employers and victims about laws that support domestic violence victims not losing their jobs because of activities they participate in as the result of domestic violence (court appearances, etc.)*

8. ***Recommendation:*** *The Family Violence Council should look into making EAP resources available for* ***anger management classes*** *and* ***conflict resolution classes*** *for County employees. The Family Violence Council should consider issuing a recommendation to employers in Alameda County to provide the same EAP resources to their employees.*

9. ***Recommendation:*** *The Family Violence Council should* ***pursue the development of mental health crisis intervention services*** *for family members and others at the scene of a domestic violence fatality, similar to the crisis intervention services developed for natural disasters by Berkeley Mental Health.*

ALAMEDA COUNTY DEATH REVIEW TEAM[1]
Alameda County Family Violence Council[2]

The Alameda County Death Review Team is established under the direction of the Alameda Family Violence Council and in accordance with California Penal Code §11163.3, 11163.4 and 11163.5.

I. Statements of Purpose

The Death Review Team (DRT) is a multi-disciplinary, multi-agency team whose goal is to improve the systemic response of public and private agencies to domestic violence through the identification and review of deaths related to domestic violence. The purpose of the DRT is:

1. To gather information in order to develop recommendations for agency policies; to identify needed resources; and, to provide information to the public with the purpose of reducing the incidence of domestic violence.
2. To assist coordination between various agencies involved in domestic violence cases, including providing a safe confidential forum for inter-agency discussion.

DRT is not an 'interventionist' team (intending to make something happen in a particular case) but a systems-review team (intending to look at the way a case was handled) in order to improve Alameda County's response to domestic violence. Any reporting of information from the team will occur in general, summarized terms, without identifying information.

II. Reporting Processes

The DRT will summarize its work in an annual report sent to the Family Violence Council, including:

1. Only summarized data and without identifying information from specific cases;
2. Recommendations for system improvement, resource's development.

The goal of reports to specific agencies will be for the purposes of developing a common language between departments, identifying needed resources, and identifying barriers to interagency cooperation. Any reports with identifying information will be destroyed after review by the committee.

III. Procedures

The organizing committee has agreed to begin with identifying a limited number of cases each month, with the eventual goal of being able to identify all cases related to domestic violence. The identification of cases will rely on the definition of domestic violence below.

The DRT organizing committee has further agreed:

1. Not to limit the cases reviewed to deaths of women, but include both men and women.
2. Not to wait for cases to be adjudicated before reviewing them because of the time lag involved in doing that.
3. To include suicides and homicides.

The DRT will be coordinated with the Child Death Review Team in order to coordinate the review of both adult and child deaths.

Neither representatives of the press nor advocates of particular cases will be allowed at DRT meetings.

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[1] Chairperson: Mary A. Duryee, Ph.D.

[2] Chairman: Hon. Vern Nakahara, Superior Court of Alameda County

The meetings will not be tape-recorded. All requests for guest attendance will go to the chairperson who will decide yeah or nay.

No written record of the meetings will be maintained. Only one copy of data collection forms which include victims names will be kept in a confidential file in the Superior Court. Data will be distributed for discussion at each meeting and re-collected. Participating members will take only the name of victims and suspects and their birthdates to their home agencies to check their records for information about the case.

At each meeting the reason for closing or keeping a case pending will be recorded.

IV. Confidentiality

The information shared at the DRT meeting is confidential and may not be revealed to others by DRT members, nor is it discoverable by a third party [Cal. Penal Code §11163.3(e)]. Members and visitors to the DRT will sign a Confidentiality Agreement.

IV. Definition of Domestic Violence

1. For the Purposes of the DRT, domestic violence is defined as the following acts which lead to a fatality by a family member or household member:
   a. Intentionally or recklessly causing or attempting to cause bodily injury to a family member or household member.
   B. Intentionally or recklessly causing or attempting to cause sexual assault to a family member or household member.
   C. Intentionally or recklessly causing or attempting to cause a family member or household member to have a reasonable fear of bodily injury to that family/household member or another.

2. Family member or household member is defined as adults or minors who are one of the following:
   a. A spouse or former spouse.
   b. A person who regularly lives or use to live in the household;
   c. A person who is dating or use to date the alleged abuser;
   d. A person who is having or use to have a sexual relationship with the alleged abuser;
   e. A person who is related by blood or adoption or legal guardianship;
   f. A person who has been or currently is related by marriage;
   g. A person who has a child with the alleged abuser;
   h. A child of a party or a child who is the subject of an action under the Uniform Parentage Act, where the presumption applies that the male parent is the father of the child to be protected.