Contra Costa County Domestic Violence Death Review Team Report
Executive Summary
March 2003

Contra Costa County's Domestic Violence Death Review Team has reviewed deaths from 1997, 1998 and 1999, 20 of which were deemed to involve domestic violence. Eight females died, 7 by homicide at the hands of men and 1 by suicide. Two were children. Twelve males died, 8 by suicide, 2 by homicide and 1 each by accidental and natural causes. There were 6 cases involving attempted/completed homicide followed by suicide, accounting for 9 deaths. The majority of deaths occurred among couples during a time of separation. Firearms were used in over half of the deaths. Two children were killed, one child attempted to kill and several witnessed episodes and were left without available parents due to domestic violence. Less than one quarter of the deaths involved people either subject to or protected by restraining orders.

Conclusions

1. Local statistics are proving true what national data have shown: The most dangerous time of a relationship is during the time of separation.
2. Firearms were used in the majority of both homicides and suicides in domestic violence cases.
3. Children remain both direct and indirect victims of domestic violence.
4. The majority of female domestic violence deaths are the result of homicide by males. The majority of male domestic violence deaths are the result of suicide.
5. Domestic violence deaths are not confined to any specific region of Contra Costa County.
6. Domestic violence deaths are not confined to any specific ethnic/cultural group in Contra Costa County.
7. The majority of people involved in incidents reviewed are not known to have sought services from public or private domestic violence service agencies.
8. A majority of deaths involved individuals who were neither subject to or protected by restraining orders.

Recommendations

1. Recognizing that separation is a critical time, all persons working with individuals involved in violent relationships need to be aware of the potential for lethality and promote the development of a safety plan which may include:
    a. Emergency protective orders and/or restraining orders.
    b. Alternative housing and/or shelter.
    c. Appropriate referrals for all family members.
2. When restraining orders are in place and/or arrests occur, firearms should be confiscated whenever possible.
3. The safety and welfare of children should be considered, assessed and documented in all domestic violence incidents.
4. First responders should document the presence of children, assess the safety and welfare of the children, and interview children in all domestic violence incidents.

5. Community outreach and education regarding domestic violence must reflect the cultural/ethnic diversity of Contra Costa County. Services must also reflect this diversity.
6. The countywide use of the Domestic Violence Report/Supplemental by law enforcement agencies and centralized computer data entry by the Sheriff's Department has improved significantly and is essential for agencies dealing with domestic violence.
7. Government and private agencies must continue to develop and implement methods for identifying and coding cases involving domestic violence.
8. Multidisciplinary efforts to address domestic violence treatment and intervention should continue and be further enhanced.
9. We recognize the value of the services provided by public and private agencies and encourage referral to and collaboration with these agencies by all involved with individuals involved in violent relationships. These agencies provide services that are essential for preventing domestic violence deaths, and require on going fiscal and political support.

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History of Domestic Violence Death Review Teams

Domestic Violence Death Review Teams

Domestic Violence Death Review Teams began in the early 1990's, with San Francisco and Santa Clara Counties doing some of the earliest reviews. Domestic Violence Death Review Teams (DVDRTs) now exist nationally, and several states have passed laws authorizing or encouraging the formation of DVDRTs while addressing a variety of issues related to participants and confidentiality. California Penal Code sections 11163.3-11163.5, Chapter 710, Statutes of 1996 deal with DVDRTs in California. In 2002, California held statewide meetings of DVDRT representatives; three members of our DVDRT attended. Further, the National Domestic Violence Fatality Review Initiative hosted the first ever National Conference on Domestic Violence Fatality Review in Phoenix, Arizona. Over 300 people attended that conference, which was supported by the Office on Violence Against Women and featured many prominent presenters and participants from throughout the nation; one member of our DVDRT attended.

Locally and nationally DVDRTs seek to conduct reviews within "a culture of safety in which domestic violence deaths are reviewed through the lens of preventive accountability." (Neil S. Websdale, et al, "Juvenile and Family Court Journal," Spring 1999, p. 61-74) Blaming is not to be a part of the picture. Teams seek to employ models familiar in the fields of medicine and aviation to review domestic violence deaths thoroughly and honestly so as to recognize the ways in which such deaths are preventable. The work is challenging and time consuming, and requires that various and diverse perspectives be represented. In several locations, patterns have been recognized that have led to system changes which resulted in altered services and, we believe, reduced deaths within specific communities. Domestic Violence Death Review Teams are viewed as critical to improving responses to domestic violence, enhancing collaboration among involved agencies, reducing liability and saving lives. (Neil S. Wedsdale, "The Police Chief," July 2001, p. 65-73)

Contra Costa County's Domestic Violence Death Review Team

The Contra Costa County Domestic Violence Death Review Team was established in 1998. Its creation was the product of the joint efforts of Contra Costa Health Services and Contra Costa Office of the Sheriff. Case reviews began in August 1999, following the development and implementation of operating protocols. The protocol outlines goals, definitions, team membership, confidentiality, case criteria, procedures and reports. The primary goals of the DVDRT are to 1) generate better domestic violence data and 2) identifying potential gaps in

service coordination in an effort to improve existing services delivery and policies. Achievements of these goals will eventually diminish/reduce/prevent not only deaths related to domestic violence, but future incidences of domestic violence.

In collaboration with Contra Costa Health Services' Community Health Assessment, Planning and Evaluation Group, a computerized domestic violence death review data base is being developed for data analysis purposes. It should be functional by early 2004. It is anticipated that future reporting will benefit from this development.

Contra Costa County's Domestic Violence Death Review Team's first report was published in November, 2000. The first report contains more detail regarding the process of creating Contra Costa County's Domestic Violence Death Review Team and of case reviews. Deaths from 1997 were reviewed first and this data is in the first report. This report includes information from deaths from 1998 and 1999. Deaths that are still open to adjudication are not reviewed by the DVDRT.

Categorization of Deaths

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

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

- **Domestic Violence Related** Cases are considered domestic violence related if the death occurred in the midst of an episode of domestic violence but did not necessarily involve one partner killing themselves or the other partner. If one partner killed children of the other partner, or if a police officer were killed while responding to a domestic violence call, it would be considered a *domestic violence related death*.

- **Domestic Violence Motivated** Situations where a person committed suicide after the break up of a relationship involving domestic violence, or when a former partner killed their ex-partner's new partner would be considered to be *domestic violence motivated*.

- **Not Proven Domestic Violence** The DVDRT reviews cases in which a current or prior history of domestic violence is documented or suspected, but the link to the death is not clear. For example, if a person victimized by domestic violence died of a drug over-dose the death would be considered to be *not proven domestic violence.*

- **Not Domestic Violence** In some situations, original suspicions that domestic violence played a role in a person's death prove to be unfounded after further information is available. These cases are classified as *not domestic violence*, and presumably fall into the same category as the deaths in the county not reviewed by the team.

Results

Deaths Reviewed from 1998

Fifteen deaths were selected for further review from all deaths in Contra Costa County in 1998 based on documentation or suspicion that domestic violence may have been involved. Three deaths involve cases not yet adjudicated, and therefore considered open. These deaths have not been reviewed. Twelve deaths have been reviewed. Two deaths were classified as not domestic violence. No deaths were classified as not proven domestic violence. Ten deaths were domestic violence cases, with six domestic violence incidents, three domestic violence related, and one domestic violence motivated (Table 1). All deaths involved opposite sex intimate partners.

Of the ten domestic violence deaths in 1998, there were four homicides, five suicides, and one natural death due to complications of paralysis caused by a gunshot wound suffered during a domestic violence related shooting years before. For 1998, there were 62 homicides and 98 suicides total, thus linking domestic violence to at least 6.5% of homicides and 5% of suicides. Three females died, 2 of them sisters aged 1 and 3 years old. All female deaths resulted from homicide via gunshot. All three females were Hispanic. Seven men died, one by homicide, five by suicide and one natural death. Three men were Caucasian, three were Hispanic and one was Filipino. All men who died were adults. Firearms were used in seven cases, knives in one, and hanging in two. (Table 2, Table 3 and Table 4)

Suicide was preceded by homicide or attempted homicide in four cases. One case involved a man who had killed his girlfriend by setting fire to the house with her in it. The girlfriend and house were in a nearby county, and the homicide preceded the suicide by a few hours. The homicide in this case is not included in Contra Costa County's data because the woman died out of county. The case was referred to the appropriate county for review. Events preceding this event are not known to us. Another case involved a man who attempted murder, but his gunshots missed his girlfriend who fell to the ground, pretending to be shot. He shot himself in the head and died. Further information regarding the situation is not available to us. The third case involved a man who murdered his wife and then killed himself. The woman was in the process of trying to leave the relationship. The final homicide/suicide case involved a man who came to his girlfriend's home to get her, as she had said she was leaving him. Other family got involved, his girlfriend escaped, he held their two daughters hostage for more than 24 hours,

and eventually shot their daughters and himself; all three died. Of the four who committed suicide after homicide or attempted homicide, three were Hispanic and one was Filipino. The additional suicide involved a Caucasian man who hung himself on a utility pole in a very public location at an outdoor event he knew his wife was attending. She was attempting to leave the relationship and a custody battle was underway. All five of the men who committed suicide had been perpetrators of domestic violence prior to the events listed above.

Homicide occurred in four cases, three of which are listed above as homicide/suicide situations. The fourth homicide is a case where a woman stabbed her estranged husband in his residence. The husband had left the relationship in 1997 because his wife was with a new man, had a substance abuse problem, was stealing from him, and had been abusive to him. This relationship involved violent behaviors on the part of both the woman and her estranged husband prior to the homicide. Both parties were Caucasian.

The final death involved a Caucasian man who died a natural death from complications of paralysis caused by a gunshot wound inflicted years ago by his step daughter. She had witnessed his abuse of her mother and had reported to friends that she wanted to protect her mother from him. Complete details of the gunshot incident or the relationship around that time were not available to us.

Table 1
Classification of Deaths, 1998

Classification	Number of deaths
DV Incident	6
DV Related	3
DV Motivated	1
Not Proven DV	0
Not DV	2
Total	12

Table 2
Cause of Death by Gender, 1998

	Male	Female	Total
Homicide	1	3	4
Suicide	5	0	5
Accidental	0	0	0
Natural	1	0	1
Total	7	3	10

Table 3
Ethnicity of Decedent by Gender, 1998

Ethnicity	Male	Female	Total
African American	0	0	0
Caucasian	3	0	3
Filipino	1	0	1
Hispanic	3	3	6
Native American	0	0	0
Total	7	3	10

Table 4
Cause of Death by Ethnicity, 1998

Cause	African American	Caucasian	Filipino	Hispanic	Native American	Total
Homicide	0	1	0	3	0	4
Suicide	0	1	1	3	0	5
Accidental	0	0	0	0	0	0
Natural	0	1	0	0	0	1
Total	0	3	1	6	0	10

Deaths Reviewed from 1999

Though reviews are not yet complete, nineteen deaths were selected for further review from all deaths in Contra Costa County in 1999 based on documentation or suspicion that domestic violence may have been involved. Five deaths have been reviewed thus far. Of the five, one was classified as not domestic violence, three were not proven domestic violence, and one was a domestic violence incident.

One death from 1999 clearly involved domestic violence. A man and woman were arguing about her leaving the relationship when he took out a gun and shot at her. Though injured, she fled and the man was found with a self inflicted gun shot wound to the head. He died at the hospital. Both parties were African American.

Thus far, there are three deaths from 1999 categorized as not proven domestic violence. Two of the deaths were those of a couple with no known domestic violence history. The man had been convicted of bank fraud and was to go to prison very soon. The man and woman were found lying next to each other in bed, both dead due to a single gunshot wound to the head. The man had shot his wife and then himself. There was no evidence of struggle, and there was a suicide note written by the man. Team members could not be certain whether or not the woman had agreed to be killed and thus could not determine with certainty if this case involved domestic violence. The other death that was considered not proven domestic violence was the suicide of a woman who had been previously involved in violent relationships, was constantly fearful an ex-husband would find and assault her, and had alcohol, drug and mental health issues that were active and untreated at the time of her death. What role her being a survivor of domestic violence played in her alcohol, drug and mental health issues is unclear, as is the role it played in her decision to kill herself.

Deaths Reviewed from 1997, 1998, and 1999

All told, Contra Costa County's DVDRT has reviewed 38 deaths from 1997, 1998 and 1999. Twenty were determined to be domestic violence deaths; 13 domestic violence incidents, 6 domestic violence related, 1 domestic violence motivated. These 20 deaths involved 17 separate couples involved in relationships with domestic violence. Of the eighteen other deaths reviewed, 7 were not proven domestic violence and 11 were not domestic violence. (Table 5) It is likely that some of the seven deaths classified as not proven domestic violence would be considered domestic violence cases if further information were available. Twelve males died, all of them adults. Eight females died, 2 were children ages 1 and 3. There were 9 homicides, 9 suicides, 1 accidental drowning while being chased by police and 1 natural death years after a gun shot wound. Seven of the eight females died of homicide at the hand of males, while one female committed suicide. Eight of the 12 males committed suicide, while 2 died of homicide at the hand of females. (Table 6) Caucasians accounted for 7 of the deaths, Hispanics 6, African Americans 5, and Filipinos and Native Americans 1 each. (Table 7 and 8)

Of the deaths deemed to involve domestic violence, over half involved firearms. Firearms were the method of death in 11 deaths, and the method of injury in the natural death due to complications of domestic violence related injury. Knives were used in 3 deaths, strangulation by hanging in 2, and a car and nail gun were the method in one death each. The hangings were both suicides, as was the nail gun death. (Table 9) Additionally, a clear majority of the deaths occurred during times of separation. Fifteen of twenty, or three quarters, of the deaths occurred during times of separation. Eight of these deaths were homicides and 7 were suicides.

There were six cases involving attempted/completed homicide followed by suicide. In five of these cases men were responsible for the deaths; a woman was responsible in one case. In three cases, the attempted homicide was not successful in that the partners were shot at but not killed. Attempted/completed homicide cases accounted for 9, or nearly half, of the deaths reviewed. One case involved homicide in a nearby county and suicide in Contra Costa County. The total number of deaths attributable to this episode is not know, but it is clear there were at least 2, though only one occurred in and was reviewed by Contra Costa County's DVDRT. Three cases involved unsuccessful homicides and successful suicides, thus accounting for 3 deaths. One case involved a man killing his wife and then himself, thus accounting for 2 deaths. Another case claimed three lives, a man and his two daughters, ages 1 and 3 years old. Five of the six attempted/completed homicides/suicides clearly occurred during times of separation. Details of the relationship in the one remaining case were not available for review.

Children were frequently affected by the deaths involving domestic violence. In one case a preschool age child witnessed a couple arguing and physically fighting in which the woman stabbed the man. Though not his parents, this is clearly a traumatic event. In another case, 2 girls, ages 1 and 3 years old, were killed by their father. A teen shot her step-father in an attempt to protect her mother from his abuse. Two teen girls and their preteen brother are dealing with their mother being murdered by their father after years of him abusing her in ways

they were clearly aware of. A male toddler was found alone in the house with his parents cold, dead bodies after his father's homicide/suicide. A preschool age, school age and teen male were all left fatherless by their fathers' suicides. A toddler and grade school age female have had to deal with their mother's being in prison for killing her partner who was not either of their fathers. Adult children have also been affected by the deaths involving domestic violence.

Domestic violence deaths occurred in all regions of Contra Costa County. Three deaths occurred in Antioch, Pittsburg Richmond, 2 each in Concord, Oakley and San Pablo, 1 each in Bay Point, El Sobrante, Pleasant Hill and Walnut Creek.

In fifteen of the twenty domestic violence deaths, there was a clear history of prior domestic violence between the intimate partners involved in the incidents leading to deaths. Twelve cases account for the 15 deaths, with one case involving 2 deaths and another involving three. Males were clearly the perpetrators of domestic violence in eleven of the twelve couples involved. In one case, there appeared to have been recurrent, mutual domestic violence. Four of the six attempted/completed homicides/suicides involved relationships known to have had violent histories. In the other two cases, there was not adequate information to be clear whether or not prior domestic violence had occurred.

The majority of people involved in deaths involving domestic violence were not known to have sought services from public or private domestic violence service agencies. One woman who was killed by her partner of many years had previously been shot by him. He had been involved in a Batterer's Treatment Program 8 years before the homicide, and she had made several calls to police and STAND! Against Domestic Violence because of domestic violence. Children and Family Services were involved due to the prior shooting incident and the children in the home. The woman had requested a restraining order the same month as the killing, but it was dropped at her request. Another woman was killed by her ex-boyfriend who had previously inflicted knife and gunshot wounds upon her. The woman had prior contact with STAND! Against Domestic Violence as well as Children and Family Services and Substance Abuse Services. Three men killed themselves while subject to restraining orders, so at least Family Court Services were involved. In only one case is it clear that the woman protected by the restraining order had contacted other domestic violence service agencies. One woman killed her ex-husband while subject to a mutual restraining order. She had prior contact with STAND! Against Domestic Violence. In all, two women who had sought services were murdered, three men whose partners had sought services committed suicide, and one woman who had previously sought services killed her ex-spouse. In only six of the twenty domestic violence deaths was the DVDRT able to find evidence of seeking support services from public or private domestic violence service agencies.

Few deaths involved parties subject to or protected by restraining orders. Three men committed suicide while subject to a restraining order. One of the men killed the woman to be protected by the order prior to killing himself. One woman killed her ex-husband while she was subject to a mutual restraining order. Of seventeen separate domestic violent episodes that involved at least one death, only four, or less than one quarter, involved restraining orders.

Table 5
Classification of Deaths

Classification	Number of deaths
DV Incident	13
DV Related	6
DV Motivated	1
Not Proven DV	7
Not DV	11
Total	38

Table 6
Cause of Death by Gender

	Male	Female	Total
Homicide	2	7	9
Suicide	8	1	9
Accidental	1	0	1
Natural	1	0	1
Total	12	8	20

Table 7
Ethnicity of Decedent by Gender

Ethnicity	Male	Female	Total
African American	3	2	5
Caucasian	5	2	7
Filipino	1	0	1
Hispanic	3	3	6
Native American	0	1	1
Total	12	8	20

Table 8
Cause of Death by Ethnicity

Cause	African American	Caucasian	Filipino	Hispanic	Native American	Total
Homicide	3	2	0	3	1	9
Suicide	1	4	1	3	0	9
Accidental	1	0	0	0	0	1
Natural	0	1	0	0	0	1
Total	5	7	1	6	1	20

Table 9
Method of death by Cause of Death*

Method	Homicide	Suicide	Total*
Car	1	0	1
Firearm	6	5	11
Knife	2	1	3
Nail Gun	0	1	1
Strangulation/Hanging	0	2	2
Total	9	9	18

*Does not include deaths due to natural or accidental causes.

Conclusions

1. Local statistics are proving true what national data have shown: The most dangerous time of a relationship is during the time of separation.
2. Firearms were used in the majority of both homicides and suicides in domestic violence cases.

3. Children remain both direct and indirect victims of domestic violence.
4. The majority of female domestic violence deaths are the result of homicide by males. The majority of male domestic violence deaths are the result of suicide.
5. Domestic violence deaths are not confined to any specific region of Contra Costa County.
6. Domestic violence deaths are not confined to any specific ethnic/cultural group in Contra Costa County.
7. The majority of people involved in incidents reviewed are not known to have sought services from public or private domestic violence service agencies.
8. A majority of deaths involved individuals who were neither subject to or protected by restraining orders.

Recommendations

1. Recognizing that separation is a critical time, all persons working with individuals involved in violent relationships need to be aware of the potential for lethality and promote the development of a safety plan which may include:
    a. Emergency protective orders and/or restraining orders
    b. Alternative housing and/or shelter
    c. Appropriate referrals for all family members.
2. When restraining orders are in place and/or arrests occur, firearms should be confiscated whenever possible
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5. Community outreach and education regarding domestic violence must reflect the cultural/ethnic diversity of Contra Costa County. Services must also reflect this diversity.
6. The countywide use of the Domestic Violence Report/Supplemental by law enforcement agencies and centralized computer data entry by the Sheriff's Department has improved significantly and is essential for agencies dealing with domestic violence.
7. Government and private agencies must continue to develop and implement methods for identifying and coding cases involving domestic violence.
8. Multidisciplinary efforts to address domestic violence treatment and intervention should continue and be further enhanced.
9. We recognize the value of the services provided by public and private agencies and encourage referral to and collaboration with these agencies by all involved with individuals involved in violent relationships. These agencies provide services that are essential for preventing domestic violence deaths, and require on going fiscal and political support.

Attachment 1
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