Sacramento County

Domestic Violence Death Review Team

Annual Report

December 2003

Presented to:
Sacramento County Board of Supervisors
& Sacramento County Domestic Violence
Coordinating Council

Available on-line at: www.da.saccounty.net

I. Summary of Key Findings and Recommendations:

(A) Summary

From November 2002 to September 2003, the Sacramento County Domestic Violence Death Review Team (DVDRT) reviewed, with great scrutiny, six fatalities attributed to domestic violence that occurred in Sacramento County (County.) The committee carefully examined each case seeking to (a) improve the earlier identification of potential victims of domestic violence, (b) determine the crisis response of professional service providers, and (c) review the County's strategies for the prevention, intervention and prosecution of domestic violence.

Some recurrent problems were identified such as the co-occurrence of domestic violence with other violent crimes, victim and/or perpetrator drug and alcohol abuse and the need for better tracking and coordination of criminal and CPS cases across county and state lines.

The single greatest concern shared by all members of the DVRT was the number of children impacted by adult domestic violence in these six cases. It is well established that children in homes where there is adult domestic violence are at increased risk for direct physical abuse, neglect, accidental "caught in the cross-fire" injuries and numerous physical, psychological or behavioral health consequences. Therefore, many of the findings and recommendations target the children who are, unfortunately, caught in the middle of adult domestic violence.

(B) Key findings:

1. Despite the efforts of law enforcement, the health care network and the social service network, domestic violence related homicides continue to occur, including six deaths in the past year.

2. There were eleven (11) children identified as exposed to domestic violence among the six relationships that ended in death.

3. One child was "caught in the crossfire" and suffered injuries in utero while his mother was being punched. He died 27 days after his premature birth. There were six additional children, of either the victim or the perpetrator, not residing in the household where the domestic violence occurred, who became subjects of the resulting CPS inquiry due to this incident of adult domestic violence.

4. Two of the six victims who were assaulted and died were pregnant at the time of the assault.

5. There is a serious shortage of shelter beds available to domestic violence victims. There are only 41 beds available in the entire county, and over the last 18 years only 6 shelter beds have been added.

(C) <u>The Work of the DVDRT:</u>

The DVDRT has reviewed 31 cases of domestic violence homicides, which occurred between 1993-2003. DVDRT has looked at cases with victims who have ranged in age from as young as 27 days to a victim as old as 60 years. The victims and perpetrators have come from mixed nationalities, including Asian Pacific Islander, Caucasian, Mexican American, African American among others.

The great majority of the victims are between the ages of 21-50, and the median age for the victim and perpetrator is 32.4 and 37.6, respectively.

The number of handguns that were the means of homicide was disturbing. In 18 of the homicides a handgun was used, leaving the DVDRT with the clear sense that availability of a handgun in a home where there is potential for violence greatly increases the possibility that a violent act resulting in death will occur.

Most of the homicides, 25 out of 31, took place in the victim's house, and in 22 of those 25 events, the victim and the perpetrator were residing together. In virtually every homicide that we reviewed, there had been a history of domestic violence in the home preceding the death. In each death we reviewed during the 2002-2003 year, there were some instances of violence within the home that preceded the homicide. It was often learned after the fact that there was unreported domestic violence in the home. In some cases the prior domestic violence was reported and in some cases it was not, however, in every case there were instances of domestic violence that preceded the death.

In two of the cases reviewed this term, it was learned that there had been prior instances of domestic violence that had never been reported to either law enforcement or anyone within the social service network. In one case, the victim had been hospitalized numerous times over the ten years preceding her death with various illnesses, including bouts with alcohol. It was not until she was admitted for the last time preceding her death that the hospital learned she had suffered ongoing domestic violence in her home. In an attempt to identify domestic violence victims at the earliest possible opportunity, for the last three years (since 2000) hospitals have been screening for domestic violence upon a patient's admission. It is hoped, that through early identification, hospital personnel will be able to offer services, thus allowing the victim to break the cycle of violence.

The most troubling observation made by the DVDRT is the number of times our system has had contact with a victim and the victim still lost her life. Such is the case whether the contact was with law enforcement, Child Protective Services, or any other service provider. In three of those deaths, the victim had previously reported the defendant to the police for domestic violence. More specifically, in one case the defendant was on probation for choking the victim a year before the homicide. He had a long criminal

record, while the victim had a long history with CPS of failing to care adequately for her children. Unfortunately, she allowed the defendant to remain in her life until he eventually killed her. Her three children were present within the home at the time of the homicide.

In another case the victim was a young, ambitious nursing student. Her partner was out on bail for beating her, and had actually threatened to take her life. Upon his release from custody she began seeing him again, letting him baby-sit their child and, eventually, asked that all pending charges against him be dismissed. Weeks after that request he killed her, as he had previously threatened.

The frustrating conclusion is that while there are some red flags for homicide, there are no reliable means to determine which person is going to carry through in his threats. Even extensive agency contacts, arrests, CSP involvement, contact with service providers cannot shelter a victim from a homicidal partner. There have been cases where there have been direct, early intervention such as an arrest, or the removal of a child because of the violence in the home, that have still failed to prevent a subsequent homicide.

In spite of the foregoing, the DVDRT is confident that the system does work, and while it does not prevent every homicide, the likelihood that a victim/perpetrator will receive some intervention that may prevent a tragedy, is continually being enhanced.

Finally, the DVDRT is compelled to reiterate the fact that many of our residents are from diverse communities from all over the world. In some countries, due to religious, cultural or other reasons, domestic violence is not seen as a significant problem.

(D) Key recommendations:

1. In order to design and implement system-wide improvements to address the needs of children in homes where domestic violence is present, the County should seek outside funding in the amount of $50,000 per year for 3 years for the implementation of guidelines from Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice (Recommendations from the National Council of Juvenile and Family Court Judges Family Violence Department).

2. In order to improve the capacity of shelter services to accommodate adult victims and their children, the County should seek funds to increase shelter bed capacity by a minimum of 15 beds each year over the next three years.

3. The County should seek ways to raise public awareness of the impact of domestic violence on children. In order to foster institutional change regarding children and domestic violence, the County should identify and disseminate web-based instruction regarding the impact of domestic violence on children.

4. In order to identify and address safety needs of domestic violence families, the County should encourage all service provider agencies to explore the implementation

of procedures for lethality assessment and appropriate response protocols. The lethality assessment is a one-page questionnaire in which specific questions are asked of a victim to determine whether the person's life is in danger, and the relationship is likely to result in serious bodily injury or death.

5. In order to more effectively and efficiently review and collect data relative to domestic violence fatalities, the County should explore the idea of funding for staff support for DVDRT meetings, data collection, data analysis and preparation of the annual report. A staff person is necessary to allow DVDRT to do the job it has been designed to do. Additionally, a staff person would assist the DVDRT in going beyond law enforcement circles and connecting with those in the medical community as a way to follow-up on a broader area of domestic violence related homicides.

II. Summary of cases reviewed for this report

A. Age of victims and perpetrators: The mean age of adult victims was 38.5 with a range of 23 to 55. The mean age of perpetrators was 35 with a range of 30 to 46. A single child, age 27 days was also murdered.

B. Gender of victims and perpetrators: Five out of six perpetrators were male.

C. Relationships between victims and perpetrators: All six fatalities involved DV in heterosexual relationships. One of the couples was married, two were living together, and three were, or had been, dating.

D. Locations of the homicides: Five of the six homicides occurred in the victim's homes.

E. Means or weapons used: Two of the victims were killed by handguns, one was stabbed to death and three were beaten to death, including one woman who was beaten and strangled to death.

F. Prior DV reports, warrants or arrests: All six victims had suffered prior domestic violence at the hands of the perpetrators. Two of the six victims had reported the perpetrators to police for prior acts of domestic violence.

   One of the perpetrators was out on bail for domestic violence, and one of the perpetrators was on probation for domestic violence.

G. Prior Threats: Three of the perpetrators threatened to kill their victims within weeks/months before they actually did it.

   Four of the six perpetrators had never been arrested or convicted of domestic violence.

H. Reluctant Victims: Each of the six victims was involved in a marriage or dating relationship with the perpetrator at the time of their death.

Four of the six victims maintained ongoing relationships with their eventual killers, despite the fact that the perpetrators had previously assaulted them or threatened to kill them.

Two of the six perpetrators had multiple contacts with law enforcement for abusing the victims they eventually killed.

I. Collateral damage (other injured victims, property damage, impact on the community): The collateral damage to the community was significant, and cannot be overlooked.

- Seven children lost their caregiver-parents to murder.
- Sacramento City College lost a nursing student, which caused at least one of the victim's classmates to contact WEAVE for counseling.
- Five of the six victims were mothers with minor children, and the mothers were the sole provider.
- Three children were percipient witnesses to murder.

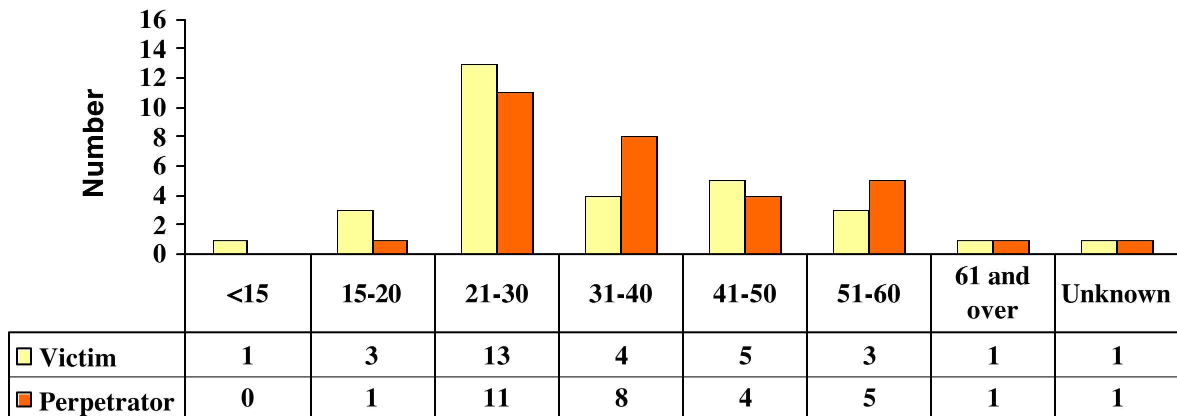
J. Points of contact with professional intervention services prior to fatal event:

- Law Enforcement: Two perpetrators had prior contact with law enforcement for domestic violence-related events; two victims had filed for orders of protection.
- WEAVE: One victim contacted WEAVE.
- CPS/APS: Seven children had prior contact with CPS.
- Health Care Professionals: Three victims and one perpetrator had contact with health care professionals within one year leading up to the fatal event; one report of suspicious injury had been submitted to law enforcement by a health professional prior to the fatal event.

III. Homicide Data

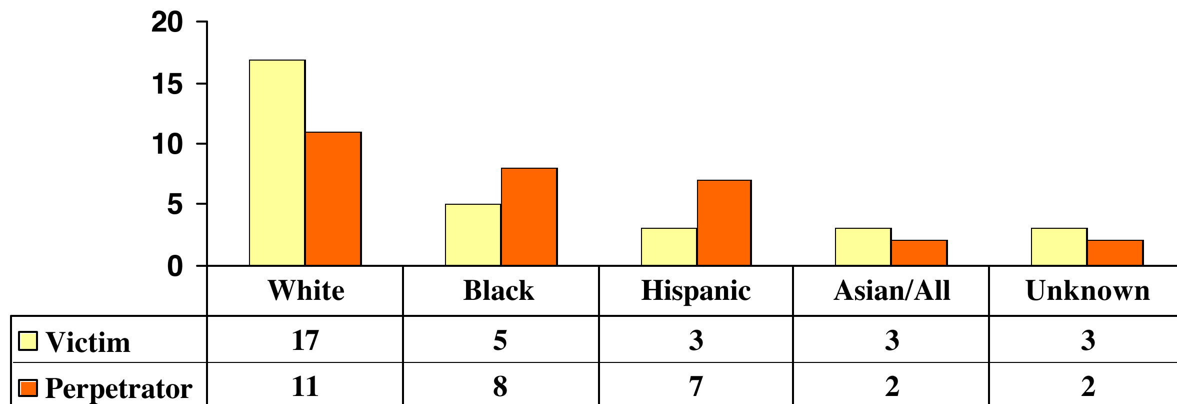
As of September 2003, the Domestic Violence Death Review Team has reviewed 31 cases, which occurred between 1993 and 2002. Of the 31 reviewed cases, victim's age range was from 1 through 71 years, with an average age of 32 years. The perpetrator's age range was from 18 through 77 years, with an average age of 37 years (Graph 1).

Graph 1. Victim and Perpetrator Age Distribution



	<15	15-20	21-30	31-40	41-50	51-60	61 and over	Unknown
Victim	1	3	13	4	5	3	1	1
Perpetrator	0	1	11	8	4	5	1	1

Graph 2. Victim and Perpetrator Race/Ethnicity Distribution



	White	Black	Hispanic	Asian/All	Unknown
Victim	17	5	3	3	3
Perpetrator	11	8	7	2	2

Table 1. Weapon Used in the Homicide

Weapon Used	Count
Handgun	11
Shotgun	2
Shotgun and handgun	1
Unspecified Firearm	4
Other Weapon	9
Unknown	4
Total	**31**

Table 2. Type of Homicide

Homicide Type	Cases
Multiple Homicide	4
Multiple Homicide, only one Fatality	1
Single Homicide	25
Unknown	1
Total	**31**

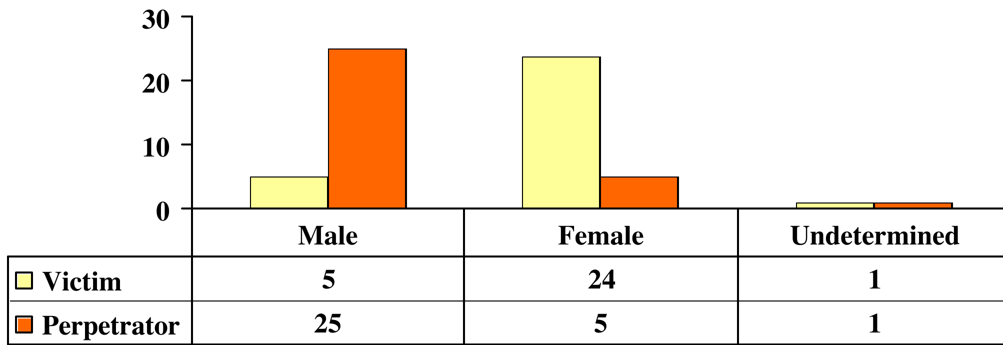
Table 3. The Place of Homicide Occurred

IV. Place of Homicide	Yes	No	Unknown	Total
Homicide Occurred in Victim's Home	26	5	0	31
Perpetrator and Victim Lived in the Same Home	22	8	1	31
Children Under 18 Living in the Household	16	14	1	31

Table 4. Relationship Between Victim and Perpetrator

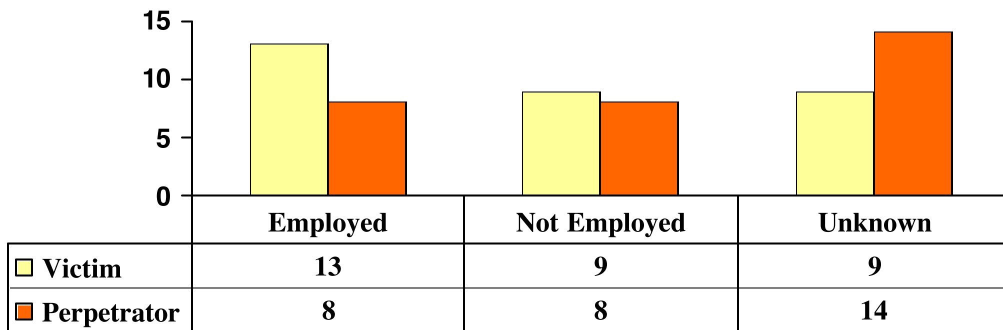
Relationship	Count	Length of Relationship	Count	Relationship Status	Count
Spouse	18	0-2 years	5	Living together, details unknown	16
Cohabiting	5	2-5 years	2	Living together, no discussing of separation	3
Co-parent	3	6-10 years	3	Living together, dis cussing separation	2
Dating	3	10 or more years	6	Separated for less than 1 year	4
Unknown	0	Unknown	11	Never living together	6
Total	**31**	**Total**	**31**	A. Total	**31**

Graph 3. Gender of Victim and Perpetrator



	Male	Female	Undetermined
Victim	5	24	1
Perpetrator	25	5	1

Graph 4. Employment of Victim and Perpetrator



	Employed	Not Employed	Unknown
Victim	13	9	9
Perpetrator	8	8	14

Table 5. Perpetrator under the Influence

Influence	Yes	No	Unknown	Total
Alcohol	5	10	16	31
Illegal Drugs	3	13	14	31
Previous Suicide Attempts	5	6	20	31
Previous Physical Violence in the Relationship	16	2	13	31

IV. Summary and Responses to Prior Recommendations

Actions Taken on Prior Recommendations of the Sacramento County Domestic Violence Death Review Team

Recommended Action	**Response**

DVDRT Report 2002

Recommended Action	Response
The County should act to ensure a sufficient number of shelter beds are available for victims of DV and their families. WEAVE should keep data on this issue.	Only WEAVE and My Sister's House currently offer beds to DV victims. WEAVE's data shows that shelters must turn away between 90 and 100 families needing emergency shelter in an average month after reaching occupancy limits. No additional beds were added for victims of DV in the past year, despite our recommendation to do so. In the past 18 years, the number of DV shelter beds in the County has increased by only 6.
Train law enforcement to inform parties in a DV incident that law enforcement has a mandatory reporting duty if children are present and that CPS may take action to protect children in violent homes.	Sacramento Police Department has begun to document children at DV scenes and report to CPS in certain cases. The District Attorney's office also makes CPS reports in cases it processes.

DVDRT Report 2001

Recommended Action	Response
The County's DVCC should reactivate the Workplace Violence committee to train employers on DV, and explore legislation to require posting of employee's rights re leave of absences in DV cases.	No action taken.
The County should ensure that the appropriate authorities develop a standard statewide DV reporting form.	A statewide form has been developed but has not yet been implemented; it should be in use in 2004.

Advocates within each of Sacramento's immigrant communities be identified and educated in DV, through education and outreach to community leaders by the County.	More organized outreach to immigrant communities is needed. WEAVE is working with the Hmong Heritage Assn. My Sister's House (an Asian DV shelter) is doing outreach and education on DV. The District Attorney's Multi-Cultural Community Council is the only group reaching out and educating immigrant communities. The County and agencies such as the Department of Human Assistance should be doing it as well.
Combined effort by government, community leaders and faith community needed to train law enforcement and first responders to deal with cultural obstacles in responding to DV situations.	A collaborative educational conference sponsored by law enforcement, the District Attorney's Office, the Attorney General's Office, & Dept. of Health Services to be held in April 2004 will include training on outreach to the immigrant communities. My Sister's House sponsored a 2003 conference on this topic.
The County should evaluate translation resources available to law enforcement, social service and health care providers, and implement a more practical/helpful system.	The DVCC has catalogued translators in the County.

DVDRT Report 2000

The Domestic Violence Coordinating Council should study and propose laws or procedures, which would enable the DVDRT to obtain mental health records.	No action taken.
Minor children either present or in a family in which a DV homicide occurs should be immediately and separately interviewed.	While this is occurring on occasion, it is still not required that first responders in Sacramento County interview children, and do so separately.
CPS should be notified whenever there are surviving children after a DV homicide to supervise placement, whether or not the child was at the scene.	Although inconsistent, there has been improvement in reporting by police agencies and supervision of placement by CPS of children surviving a DV homicide.

A system should be put in place to notify the DA's Victim-Witness Unit in murder-suicide cases, so surviving children can receive services.	If it comes to their attention, either through the media or another source, the DA Victim-Witness Unit contacts families in DV homicides, even before receiving a crime report. No systematic response exists.
DA's Victim-Witness Unit should notify the guardians of all children surviving DV homicides that victim-witness funds for counseling are available.	This recommendation has been implemented, but only as to cases which are handled by the District Attorney's Office.

All first responders should prepare incident reports after responding in a DV case and submit to appropriate law enforcement agency.	Progress is being made in this area; the Fire Department has agreed to begin this tracking.

Health care providers make more efforts to ensure patients are screened for DV and appropriate referrals are made.	Health care institutions in the County are either screening or developing policies to implement DV screening, as required by law; screening of pediatric patients is still an issue.

The County should facilitate community education about the dynamics of domestic violence through the faith community, media and employers.	WEAVE 2001 media campaign, "Break the Silence"; WEAVE continues to urge employers and faith community to incorporate DV information in policies/practices · Catholic diocese incorporated DV education classes · Hmong church did outreach after the Xiong family deaths in 1999 · City of Sacramento trained most of its workforce and adopted a no-tolerance policy in DV · Sacramento Sheriff's DV Response Team provided community education and law enforcement training in 2001 · Sacramento employers need to be encouraged to educate workers on DV

The County should educate the community about mental illness to (1) de-stigmatize counseling and (2) to help families recognize, not minimize, lethal threats in DV situations.	The District Attorney does education & outreach on recognizing lethality in DV cases, but there has been no countywide effort to educate the community on the effects of mental illness on domestic violence.

Health care providers should screen for mental illness in DV situations, foster mental health assessments and intervention.	In 2001, Sacramento County Division of Mental Health contracted with UCD Dept. of Psychiatry to provide 8 hours per week of psychiatric consultation and treatment at a primary care clinic.
911 dispatchers should receive additional training on the dynamics of domestic violence.	Only dispatchers, not operators, receive updated annual training on DV, although all receive initial DV training. CHP dispatchers received special training in 2001 on DV calls from the District Attorney's Office.
Educate law enforcement agencies on interviewing/videotaping child witnesses at DV scenes.	Yearly advanced officer training at the Sacramento Sheriff's Dept. includes 2 hours training by a DA investigator on reporting in DV cases; Sacramento Police Department now has yearly in-service training on this issue, & may call investigators from Family/Youth Services to interview child, depending on situation. More specific training needed.
The County should establish a pilot program to identify high-risk cases in DV and monitor high-risk families with home visits.	There has been a partial effort to implement this recommendation. All public health nursing & home visit programs in the County now screen for DV and offer referrals through programs benefiting families with newborns.

V. Appendices

(A) The DVDRT

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

(B) Purpose

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

(C) Confidentiality

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

(D) Membership

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

Sacramento District Attorney's Office
Sacramento Sheriff's Department
Sacramento Police Department
Folsom Police Department
Sacramento Probation Department
Sacramento Coroner's Office
Law Enforcement Chaplaincy -- Sacramento
California Attorney General's Office
California Department of Justice Automated Systems Programs
Sacramento Fire Department
Sacramento County Department of Health and Human Services:
Division of Public Health Promotion and Education

Division of Child Protective Services
Division of Mental Health
Sacramento County Office of Education Prevention and Student Services
Kaiser Permanente
University of California, Davis, Medical Center
Sutter Medical Center, Sacramento
Catholic Healthcare West/Mercy Sacramento
WEAVE, Inc. (Women Escaping a Violent Environment)

(E) Implementation

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

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

(F) Selection and Review of Cases

The process for the selection of cases to be reviewed has been subject to some modification during the history of the DVDRT. The enabling statute resolves any issue with respect to a conflict of interest by health care or social services providers, but does not resolve the issues for the law enforcement and prosecution members of the team.

Since the review of certain cases in the DVDRT would raise the potential of use of such information in the criminal case, it would likely lead to litigation in the criminal case as to whether any applicable evidentiary privileges had been breached through the DVDRT. Accordingly, the DVDRT initially reviewed only cases of murder-suicide, where no criminal prosecution was possible.

After a period of time, the team extended its scope to include cases where the criminal prosecution has been completed to the point of sentencing or dismissal by the time of the DVDRT review. This change in scope necessarily required the input of the District Attorney's Office in the case selection process. This led in 2001 to a shifting of the principal responsibility for the selection of cases from the police law enforcement agencies to the District Attorney's Office.

Generally, cases identified for review arise from the Sacramento Police Department or the Sacramento Sheriff's Department. When a case has been selected, the District

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

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

As part of the review process for the preparation of this annual report, the Team determined a need to modify the case selection process in the future to assist in better examination and review of cases. A procedure is being implemented where a principal person is assigned for each case, who will be responsible for making the initial basic presentation of case information, and ensuring that certain basic data is provided for the data-base.

By virtue of both the existing selection process and time limitations, the data-base findings as to the cases reviewed cannot be considered exhaustive, or statistically representative.

(G) Domestic Violence Death Data Collection

For purposes of facilitating data collection, the DVDRT developed a data collection sheet for use with each case. The purpose behind the data collection sheet was for each agency to complete that portion of the sheet for which the agency had data for a particular case. The data sheets submitted by each agency on a particular case would then be combined so that the data could be entered in a database to help analyze the information the team had reviewed. A copy of the data collection form was appended to the DVDRT report in 2000. In practice, the actual use of the data sheet in the manner was less than consistent. In preparation for this report, the Team recognized that the data collection process as it actually occurred did not follow the procedures the Team had originally envisioned when the data collection form and its associated processes were originally designed. The Team is working to implement a system of data collection that will realistically match procedure with practice and actual data collection. As part of that process Sacramento County Public Health Division has contributed the services of an epidemiologist to assist in revising the process and provide professional expertise in the compilation of the data.